Fistula Care *Plus*

Associate Cooperative Agreement
AID-OAA-A14-00013

Annual Report
October 1, 2015 to September 30, 2016

Managing Partner: EngenderHealth;
Associate Partners: The Population Council, Dimagi, Direct Relief, Fistula Foundation, Maternal Health Task Force, TERREWODE

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Fistula Care *Plus*

EngenderHealth for a better life

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ACRONYMS AND ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
AMTSL	Active management of the third stage of labor
ANC	Antenatal Care
BMGF	Bill and Melinda Gates Foundation
BMMMS	Bangladesh Maternal Mortality Survey
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bangabandhu Sheikh Mujib Medical University
C-Section	Cesarean Section
CBO	Community Based Organization
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CDDM	Clinical Data for Decision-Making
CE	Community engagement
COSECSA	College of Surgeons of East, Central and Southern Africa
CSME	Maternal and Child Health Center (Centre de Santé Mère / Enfant)
CRNFO	Centre National de Référence pour la Fistules Obstétricales
CYP	Couple-Years of Protection
DGHS	Directorate General of Health Services
DHIS	District Health Information System
DHS	Demographic and Health Survey
DRC	Democratic Republic of the Congo
ECOWAS	Economic Community of West African States
ECSACOGS	East, Central and Southern Association College of Obstetricians and Gynecologists
EH	EngenderHealth
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EMRS	Electronic medical records system
ESOG	Ethiopian Society of Obstetrics and Gynecology
FBO	Faith Based Organization
FC	Fistula Care
FC+	Fistula Care *Plus*
FCoP	Fistula Community of Practice
FF	Fistula Foundation
FIGO	International Federation of Gynecology and Obstetrics
FMOH	Federal Ministry of Health (Nigeria)
FP	Family planning
FPM	Female pelvic medicine
FY	Fiscal year
GOB	Government of Bangladesh
GMNHC	Global Maternal and Newborn Health Conference
HC	Health Center
HGR	General Reference Hospital
HMIS	Health Management Information System
HSD	Health Services Delivery
IDB	Islamic Development Bank
IDEOF	International Day to End Obstetric Fistula
IDPs	Internally Displaced Persons
IGL	Imagerie des Grand Lacs
IMAN	Islamic Medical Association of Nigeria

IOFWG ..... International Obstetric Fistula Working Group
IRB ..... Institutional Review Board
ISOFS ..... International Society of Obstetric Fistula Surgeons
IUCD ..... Intrauterine contraceptive device
IVR ..... Interactive voice response
J&J ..... Johnson & Johnson
LGA ..... Local Government Area
MAF ..... Medical Aid Films
MCH ..... Maternal and Child Health
MCSP ..... Maternal and Child Survival Program
ME&R ..... Monitoring, evaluation and research
M&E ..... Monitoring and evaluation
MHTF ..... Maternal Health Task Force
MNCH ..... Maternal, Newborn and Child Health
MOH ..... Ministry of Health
MOHFW ..... Ministry of Health and Family Welfare
MSRK ..... Maternité Sans Risque de Kindu
MTE ..... Mid-term evaluation
NOFIC ..... National Obstetric Fistula Center
NFTWG ..... National Fistula Technical Working Group
OF ..... Obstetric fistula
OGSB ..... Obstetrical and Gynaecological Society of Bangladesh
PHC ..... Primary Health Center
PMP ..... Performance Management Plan
POP ..... Pelvic organ prolapse
PPP ..... Public Private Partnership
PRH ..... Population and reproductive health
PROSANI ..... Le Projet de Santé Intégré
PT ..... Physical therapy
QI/QA ..... Quality improvement/ quality assurance
QIS ..... Quality Improvement Secretariat
RCOG ..... Royal College of Obstetricians and Gynecologists
RCSI ..... Royal College of Surgeons in Ireland
RCT ..... Randomized Controlled Trial
REF ..... Réseau pour l'Eradication des Fistules (Niger)
RMNCAH ..... Reproductive, maternal, newborn, child and adolescent health
SBCC ..... Social and behavior change communication
SDI ..... Service delivery improvement
SGBV ..... Sexual and Gender-based Violence
SJH ..... St. Joseph Hospital (DRC)
SMNE ..... Santé de la mère, du nouveau né et de l'enfant
SOO ..... Structured Operative Obstetrics
SWT ..... Site Walk-Through
TA ..... Technical Assistance
TOT ..... Training of trainers
TF ..... Traumatic fistula
TSHIP ..... Targeted States High Impact Project (Nigeria)
UNFPA ..... United Nations Population Fund
USAID ..... United States Agency for International Development
USAID/W ..... USAID/Washington
VHT ..... Village health team volunteer

VVF .....Vesico Vaginal Fistula
WA.....West Africa
WAHO.....Organisation Ouest Africaine de la Santé
WDI .....Women Deemed Incurable
WIF ……Women with Incurable Fistula (preferred term, Uganda)
WPI……Women with Persistent Incontinence (preferred term, Nigeria)

TABLES

FIGURES

EXECUTIVE SUMMARY

The annual report presents key accomplishments and activities for the third fiscal year (October 1, 2015 to September 30, 2016) of Fistula Care *Plus* (FC+). EngenderHealth manages the project in collaboration with international and national partners. In FY 15/16, USAID supported fistula treatment and prevention services through the FC+ project in **six** countries—Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, Togo, and Uganda. USAID also supports fistula activities in DRC, Ethiopia, Guinea, Mali, Pakistan, and Tanzania through bilateral funding. EngenderHealth also supported fistula prevention and care activities in Guinea with funds from other sources, including the Jhpiego-implemented, USAID-funded Health Services Delivery (HSD) project.

Key accomplishments during the October 1, 2015 to September 30, 2016 period included:

Objective 1: Strengthened enabling environment

- Launch of the Fistula Community of Practice (FCoP)
- International Day to End Obstetric Fistula (IDEOF) celebrations in five FC+ supported countries
- Technical guidance to Bangladesh MoH for Bangladesh Maternal Mortality and Morbidity Survey (BMMMS)
- Landscape review of national fistula strategies in ten countries
- Board participation in the G4 Alliance for Global Surgery and College of Surgeons of East, Central and Southern Africa (COSECSA)
- Participation in and support to national working group meetings in Bangladesh, DRC, Uganda, and West Africa Region/Niger
- Support for development and adoption of catheterization for prevention/conservative treatment guidelines in Nigeria
- Initiation of LABORIE partnership on urodynamics and pelvic floor physical therapy
- Collaboration with Royal College of Obstetricians and Gynecologists (RCOG) on training manual for evaluation and management of fistula, pelvic organ prolapse (POP), incontinence and related pelvic floor disorders.

Objective 2: Enhanced community understanding and practices

- 679 community volunteers/educators trained in tools and approaches to raise awareness regarding fistula prevention and repair
- 10,393 community awareness-raising activities/events conducted by program partners, reaching 6,538,530 participants
- Training and support for outreach activities of religious leaders and village committees in Uganda and Nigeria, village committees in Niger, cured fistula patients in Bangladesh
- Participation in SBCC Summit and convening of FC+ Objective 2 Experts' Workshop
- Development and roll out of new 4Q checklist for fistula screening, through brac in Bangladesh

Objective 3: Reduced transportation, communications, and financial barriers

- Completion of formative research to investigate barriers faced by women in Nigeria and Uganda and publication of findings in two reports and briefs

- Design of intervention package and evaluation research plan based on formative research findings; initiation of baseline data collection
- Completion of Nigeria communications assessment study and development of two draft study reports

Objective 4: Strengthened provider and health facility capacity

- 37 sites supported by FC+ for fistula treatment and prevention activities; 14 sites supported through other USAID bilateral support
- 3,514 surgical fistula repairs and 323 non-surgical repairs supported through FC+; 1,597 surgical repairs and 10 non-surgical repairs supported by other bilateral USAID programs
- 289 sites supported by FC+ for prevention-only activities, as well as 500 former Targeted States High Impact Project (TSHIP) sites in Nigeria where FC+ provides temporary data collection; 40 sites supported through other USAID bilateral support
- 366,038 family planning (FP) counseling sessions provided at supported sites, with FP services resulting in 195,986 Couple Years of Protection (CYP); 198,614 of these counseling sessions and 89,341 of this CYP were reported from the 500 former TSHIP facilities
- 16 surgeons trained in fistula repair
- 1,414 health system personnel trained in non-surgical fistula repair and prevention topics
- POP integration pilot logic model, indicators, and implementation plan developed

Objective 5: Strengthened evidence base

- Continued leadership in data collection and reporting using DHIS2
- Implementation of TERREWODE study on psychosocial reintegration of women with fistula deemed incurable
- Dissemination of research findings at XI International FIGO Conference, GMNH Conference, Women Deliver, and other national/international forums
- "A Call to End Iatrogenic Fistula" webinar
- Collaboration with Nigerian MOH to develop and pilot new HMIS tools

INTRODUCTION

This annual report provides a summary of accomplishments for the third fiscal year (October 1, 2015 – September 30, 2016) of Fistula Care *Plus* (FC+), a five-year Associate Cooperative Agreement (No. AID-OAA-A14-00013) supported by USAID. In this report we present data on quantitative project indicators as well as narrative updates organized into: Section I: Management Activities, Section II: Global Accomplishments, and Section III: Country Accomplishments. Global and country accomplishments are reported against the objectives of the FC+ Project Framework (see Figure 1 and Appendix V) and in alignment with the USAID-approved Project Monitoring Plan (PMP). Section II is further organized by sub-objective.

USAID support to EngenderHealth for fistula services began in FY 04/05 under the Access, Quality, and Use in Reproductive Health (ACQUIRE) and Action for West Africa Region (AWARE) Projects and continued through the Fistula Care (FC) Project, which ended on December 31, 2013. USAID/Washington (USAID/W) awarded the FC+ project to EngenderHealth, in partnership with the Population Council, Dimagi, Direct Relief, Fistula Foundation, Maternal Health Task Force, and TERREWODE, on December 12, 2013. FC+ seeks to strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia.

As of September 30, 2016, FC+ is supporting fistula prevention and treatment activities with USAID funding at a total of 326 sites in Bangladesh, the Democratic Republic of the Congo (DRC), Niger, Nigeria, Togo and Uganda: 37 treatment and prevention sites and 289 prevention-only sites. FC+ is also supporting temporary data collection at an additional 500 former TSHIP sites in Nigeria. See Appendix A for a full list of FC+ planned and actual supported sites.

In addition to the support provided via FC+, USAID provides bilateral support to fistula work carried out at 54 sites (14 treatment, 40 prevention-only) in DRC (through ProSani); Ethiopia (through Pathfinder); Guinea (through Jhpiego); Mali (through IntraHealth); Pakistan (through the Jinnah Post Graduate Medical Center); and Tanzania (through Vodafone/CCBRT).

In FY 15/16, EngenderHealth (EH) has continued fistula-related activities in Guinea through the Jhpiego Health Services Delivery (HSD) project, as well as support from the Alcoa Foundation. EH also completed the first year of engagement for fistula surgeries in Guinea supported in tandem by the Fistula Foundation (FF) and the Islamic Development Bank/Islamic Solidarity Fund for Development (IDB).

Figure 1: Fistula Care *Plus* Project Framework

GOAL: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in sub-Saharan Africa and South Asia				
Obj. 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors	*Obj. 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula*	*Obj. 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support*	*Obj. 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment*	*Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment*

SECTION I: MANAGEMENT ACTIVITIES

Overview

During FY 15/16, the global FC+ team's management activities focused on recruitment and orientation of outstanding staff positions, finalization and implementation of project subawards, workplan and budget development, and continued refinement of the project's clinical and programmatic data collection and monitoring systems. Management activities provided the oversight and operational framework that enabled the achievements described in Sections II and III. FC+ obtained approval from USAID for the FY 15/16 workplan and budget and worked on preparation for the FY 16/17 workplan and budget. FC+ provided requested inputs to the project's external mid-term evaluation (MTE).

Clinical Director Joseph Ruminjo left the project in January 2016. The former Program Finance Manager, Joseph Osei, left the project in December 2015. Anthony Asher served in the role of Finance and Administration Manager from January through June 2016; this role was taken on by Alpha Koroma in October 2016. Elly Arnoff joined the project in July 2016 as the Program Associate – Evaluation and Research.

Staffing and Recruitment

During FY 15/16, the FC+ global team was comprised of the following staff:

Lauri Romanzi: Project Director
Vandana Tripathi: Deputy Director
Joseph Ruminjo: Clinical Director (through January 2016)
Bethany Cole: Global Projects Manager
Joseph Osei: Program Finance Manager (50% LOE, through December 2015)
Anthony Asher: Finance and Administration Manager (January 2016 - June 2016)
Alpha Koroma: Finance and Administration Manager (October 2016 onward)
Isaac Achwal: Senior Clinical Associate
Lauren Bellhouse: Program Associate
Elly Arnoff: Program Associate – Evaluation and Research (July 2016 onward)
Altiné Diop: Program Associate
Karen Levin: Senior Program Associate, Monitoring and Evaluation (50% LOE)
Mark Barone: Senior Clinical Advisor – short-term technical assistance

Table 1 provides a recruitment list of open positions at the country level as of September 30, 2016. Several positions were filled at the country level in FY 15/16. All new staff at the global and country levels received orientations to EngenderHealth and USAID regulations and policies.

Table 1: Open Positions at the Country Level, as of September 30, 2016

Country	Open Positions
Bangladesh	None
DRC	None
WA/Niger	Clinical Advisor (subject to funding availability); Driver
Nigeria	Senior M&E Advisor (hired, started October 2016); Community Mobilization Associate

Country	Open Positions
Uganda	None

Project Management

FC+ leadership oversaw project management through participation in meetings with USAID/W; finalization of FY 15/16 workplans and budgets; securing USAID Mission concurrence and USAID/W approvals for subawards; and working with partners and country-level staff to facilitate FC+ finance and M&E systems, and staffing and program support.

FC+ has designed and developed a low-cost, flexible, and robust data collection and management system using the DHIS2 platform. The system has been continually updated to reflect additions and changes to data collection processes.

At the request of USAID/Washington, FC+ has continued to work with several projects supporting fistula-related work through USAID-supported bilateral funding in order to coordinate reporting of fistula-related data to USAID. FC+ was able to gather data from four bilateral projects for the current reporting period: ProSani in DRC, Pathfinder in Ethiopia, IntraHealth in Mali, and Vodafone/CCBRT in Tanzania.

FC+ launched coordinated country program reviews (CPR) involving monthly teleconferences between Clinical, Program Management and Finance staff from global and country offices to streamline and harmonize staff and programmatic functions in relation to objectives, indicators and program innovations. The FC+ Global Projects Manager provided ongoing updates of FP standards and practices for EngenderHealth through communication and support to the FP liaison in each country office.

PMP Revisions

Beginning in FY15/16, FC+ has made revisions to several indicators in the project management plan (PMP).

Indicator 4: Targets revised to reflect limitations in ability to effect HMIS adoption only in countries where FC+ has comprehensive programming, including Objective 1.

Indicator 11: Numbers reached through community awareness-raising events conducted by program partners will be disaggregated by: number reached via in-person events and number reached via mass media events.

Indicator 15: Indicator has been split into two components to reflect project achievement in total numbers of supported fistula treatments. Indicator 15a will continue to report the number of supported surgical fistula repairs, and indicator 15b will include the number of supported conservative (non-surgical) treatments for fistula. When added together, these two indicators represent the total number of supported fistula treatments.

FC+ leadership provided inputs as requested to the independent mid-term evaluation (MTE) overseen by the Global Health Performance Cycle Improvement Project (GH Pro) and directly conducted by independent consultants Deborah A. Caro, Ph.D. (Cultural Practice, LLC) and Steven Arrowsmith, MD (Fistula Foundation). FC+ leadership had the opportunity to debrief with the evaluation team and provided feedback on the main evaluation findings. Recommendations from the draft MTE report were then incorporated into the FY 15/16 workplan, submitted to USAID/Washington in September 2016. The final report will be shared with USAID by GH Pro when ready.

Partnership: Global and Country-Level

FC+ global staff worked with international project partners to develop and implement subawards and plans for their engagement in project activities. Please refer to Appendix B for a complete list of current FC+ partnerships.

During FY 15/16, FC+ identified many opportunities for partnership and collaboration with global partners to strengthen and disseminate the evidence base for improved fistula care.

FC+ has coordinated with UNFPA and its Campaign to End Fistula on several fronts: field-level activities, particularly in Nigeria; the United Nations proposal for making fistula a "notifiable condition;" participation in a half day symposium at the October 2015 Federation of Obstetricians and Gynecologists (FIGO) conference with representation from the International Urogynecological Association (IUGA), International Society of Obstetric Fistula Surgeons (ISOFS), UNFPA, USAID, the Fistula Foundation and Johnson & Johnson; activities to mark the International Day to End Fistula; and planning for the International Obstetric Fistula Working Group (IOFWG) meeting to be held in Abuja, Nigeria in October 2016 immediately preceding the biannual ISOFS meeting (see below).

FC+ was substantively engaged in preparations for the October 2016 ISOFS meeting held in Abuja, Nigeria. In addition to financial support towards the meeting, FC+ directly submitted and/or supported the submission of 36 abstracts as well as presented two plenary sessions at the conference. FC+ also contributed technical and financial support for the *Guidelines for Prevention and Management of Obstetric Fistula in Nigeria*, which was launched at the conference's opening ceremony by the Nigerian Federal Minister of Health. See Appendix T for more details on FC+ participation in ISOFS, as well as IOFWG.

As discussed in Section II, Objective 1, FC+ continues to participate at the Board of Directors level in the Global Alliance for Surgical, Obstetric, Trauma, and Anesthesia Care (G4 Alliance: http://www.theg4alliance.org/). The G4 Alliance was formed in response to growing recognition of the global burden of surgical disease and related costs in low- and middle-income countries as outlined in the Lancet Commission on Global Surgery (http://www.lancetglobalsurgery.org/). G4 Alliance goals are relevant to strengthening the enabling environment for fistula prevention and treatment programs and policies.

FC+ worked with the Demographic and Health Survey (DHS) Program to co-author a manuscript based on secondary analysis of DHS data from all surveys including the fistula module. Additional detail on these activities can be found below and in Section II, Objective 5 of this report.

FC+ has continued collaboration with the Maternal and Child Survival Program (MCSP), which has included preparing a user guide for short labor and delivery quality of care indices developed by the FC+ Deputy Director, with MCHIP/MCSP support. As the user guide is complete (http://www.mcsprogram.org/wp-content/uploads/2016/10/QoCIndexUserGuide.pdf), plans are

underway to pilot the tools at FC+ fistula prevention sites and MCSP maternal health program sites.

FC+ has continued to work with the Population Council to carry out research to build institutional knowledge about interventions to reduce barriers faced by women seeking fistula repair services in Nigeria and Uganda. This work is described in greater detail in Section II, Objectives 3 and 5 as well as in Section III: Nigeria. The Population Council subaward was modified in the third quarter to extend the scope and end date of the agreement.

During FY 15/16, country programs have progressed in finalizing and implementing in-country partnerships and subawards for facilities that receive FC+ support. As of September 30, 2016, there are 12 active subawards approved by USAID, see Table 2 for detail.

Table 2: Active Subawards as of September 30, 2016

Institution	Start Date	End Date	Number	Amount	Description
Global					
Population Council	1-Oct-14	30-Dec-16	SUBA094	$497,244	To build institutional knowledge about interventions to reduce financial barriers, particularly related to transportation, by women seeking fistula repair services with a focus on Nigeria and Uganda.
Bangladesh					
Ad din Hospital	1-Oct-16	31-Mar-18	SABD009	$62,256	To continue providing obstetric fistula prevention, detection, treatment, and reintegration services at Ad-Din Hospital, Dhaka and to continue organizing periodic fistula repair concentrated efforts at Ad-Din Hospital in Jessore.
brac	1-Jan-15	31-Dec-16	SABD007	$114,762	To identify and refer women suffering from fistula for treatment. Increase awareness of fistula and strategies for prevention.
LAMB Hospital	16-June-16	30-June-18	SABD011	$144,133	To enable LAMB Hospital to further strengthen and develop its capacity to perform surgical repair of fistula, and to increase staff and public awareness of the problem and its prevention.
Kumudini Hospital	1-Oct-16	31-Mar-18	SABD010	$69,280	To provide support to build the capacity of Kumudini Hospital to improve the quality and availability of fistula treatment services, and prevent fistula through strengthening maternal health services and increasing access to FP.
DRC					
St. Joseph Hospital	1-Sep-14	31-Dec-16	SACD002	$300,680	To improve access to quality fistula services through improved fistula service delivery, training of providers and strengthening quality assurance mechanisms.
HEAL Africa	1-Jan-15	31-Dec-16	SACD001	$229,997	To strengthen the capacity of HEAL Africa and its staff to provide accessible, quality obstetric fistula repairs and prevention services.
Imagerie Des Grands Lacs (IGL)	1-Oct-14	31-Dec-16	SACD004	$273,678	To build the capacity of IGL staff to prevent obstetric fistula through strengthening maternal health services and FP.

Institution	Start Date	End Date	Number	Amount	Description
Maternité Sans Risque de Kindu (MSRK)	1-Jan-14	31-Dec-16	SACD005	$193,105	To build the capacity of MSRK staff to prevent obstetric fistula through the strengthening of maternal health services and FP.
Panzi Hospital	1-Jan-14	31-Dec-16	SACD003	$339,230	To improve access to fistula care, build the capacity of General Reference Hospital Panzi to repair obstetric fistula, improve the clinical services provided in the hospital and prevent fistula through strengthening maternal health services including increasing access to FP.
Uganda					
Kitovu Hospital	1-Aug-14	30-Sep-16	SAUG001	$249,930	To enhance community understanding and practices to prevent fistula, improve access to treatment, reduce stigma and support reintegration of women with fistula, including those whose fistula is deemed incurable and those fistula is the result of sexual violence; to Reduce transportation, communication and financial barriers to accessing preventive care, detection, treatment and reintegration support; and to Strengthen provider and health facility capacity to improve and sustain quality services for fistula prevention, detection and treatment.
Kamuli Mission Hospital	19-Nov-2015	14-Nov-2016	SAUG003	$78,562	To provide repairs to 100 women with fistula, enhance community understanding and practices to prevent fistula, reduce barriers to accessing preventive care, treatment and reintegration support, and strengthen facility level capacity for fistula management.

In addition to work with project partners, FC+ staff participated in several meetings and coordination processes led by USAID and its flagship projects. These include meetings of the USAID PRH Gender Cooperating Agencies (CAs), training on cooperative agreement regulations held by Inside NGO, the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Global Financing Facility Consultation, meetings of the Bureau of Global Health CAs M&E Technical Working Group, and meetings of the PRH Service Delivery Improvement (SDI) CAs.

FC+ has sought other opportunities to support USAID-led and global initiatives addressing maternal morbidity. FC+ provided technical assistance on fistula and pelvic organ prolapse (POP) measurement to the Bangladesh USAID Mission-led team developing the Bangladesh Maternal Mortality and Mortality Survey and a nested clinical validation study and will provide services to patients identified through these activities. See Section II, Objective 5 for additional details. FC+ also worked with partners to develop and deliver a panel on iatrogenic fistula for the October 2016 Global Maternal and Newborn Health Conference in Mexico City and a panel on maternal morbidity for the May 2016 Women Deliver conference in Copenhagen (see Appendix C for details).

Leveraging FC+ for Additional Fistula Programming

In January 1, 2015, EngenderHealth reopened an office in Guinea to continue the work toward a fistula free generation in the country. Much effort was invested prior to this to develop resources to continue the work under the FC project, including the provision of FP services. Challenges of reopening were compounded by the Ebola outbreak that necessitated careful strategy to facilitate continuation of this work in an Ebola context. EngenderHealth successfully raised funds from the Alcoa Foundation, which has significant mining interests in Guinea, as well as the Islamic Development Bank/Islamic Solidarity Fund for Development. In January 2016, the USAID Guinea RFA-OAA-15-000024 Guinea Health Service Delivery (HSD) project for FP and maternal, newborn, and child health (MNCH) was awarded to the Jhpiego-led consortium. EngenderHealth and Save the Children are partners on the project and EngenderHealth will lead fistula prevention and repair activities aimed to implement over a five-year time frame toward a "fistula free generation" in Guinea. HSD staff have been oriented to the FC+ PMP and are reporting through the FC+ DHIS2 platform.

International Clinical Support and Technical Assistance (TA) Travel

FC+ global staff and consultants have carried out international clinical support and TA visits to seven countries during FY 15/16 (see Table 3). This travel included:

- Management visits, partner meetings (Bangladesh, DRC, Nigeria, Uganda);
- POP integration preparation, site visits (DRC, Nigeria);
- Site Walk Through support (Niger, Uganda);
- Clinical audits (Bangladesh, Nigeria, Togo, Uganda);
- Training and support for fistula repair (Togo) and PT services (DRC); and
- Gender training and programmatic advising (Nigeria).

Additionally, Clinical and M&E program staff from four FC+ countries traveled to Addis Ababa to participate in a June 2016 EngenderHealth meeting on the use of Clinical Data for Decision Making (CDDM). The meeting resulted in strengthened coordination between FC+ clinical and routine oversight and monitoring.

Table 3: International Technical Assistance Travel, October 2015 – September 2016

Traveler	Dates/Location	Purpose
Alexandre Delamou (consultant)	November 2-10, 2015/ DRC	To present at a urology conference in Kinshasa and provide management visit at subaward site at Saint Joseph in Kinshasa
Lauri Romanzi	November 14-27, 2015/ Nigeria	To attend the EngenderHealth Nigeria board meeting and site visits to POP integration sites and other supported sites
Bethany Cole Lauren Bellhouse	December 5-15, 2015/ DRC	To plan for year two subawards, DDM, and management review
Sita Millimono Dr. Kindi Diallo (consultant)	December 5-20, 2015/ Togo	To assist in clinical management during a concentrated repair workshop in Sokode, Togo
Laura Keyser (consultant) Jessica McKinney (consultant)	January 16-30 , 2016/ DRC	To provide clinical and programmatic input to build capacity and obstetric health physical therapy (POHPT) services at Panzi hospital

Traveler	Dates/Location	Purpose
Isaac Achwal Sita Millimono	March 13-18, 2016/Togo	To provide mortality audit of the single site of surgical activity, coordinated with partners (UNFPA and hospital staff) and MoH
Bethany Cole Anthony Asher	March 7-11, 2016/ Bangladesh	Management review
Lauri Romanzi	March 5-12, 2016/ Nigeria	To provide mortality audit in Katsina, Babbar Ruga NOFIC
Lauri Romanzi	March 13-19, 2016/ DRC	To provide POP integration training and site assessment of Kisenso towards expansion of FP and fistula services with Dr. Nembunzu
Lauri Romanzi	March 19-25, 2016/ Kenya	To meet with Senior Clinical Advisor to discuss overall project strategy and supporting activities, to meet with IFFP Africa office, to meet with UNFPA Kenya regarding development of a "fistula curriculum" that will inform a future Kenya National Fistula Strategy
Isaac Achwal	April 18-29, 2016/ Bangladesh	To provide assessment of Bangladesh Project Director and Senior Advisor functions; Assess clinical team activity levels; and Assess FC+ functional dynamics with a focus on our ability to execute our upcoming responsibility to render fistula care to women identified in the national Maternal Morbidities survey.
Lauri Romanzi Anthony Asher	May 1-5, 2016/ Nigeria	To attend Nigeria partners meeting
Laura Keyser Jessica McKinney (consultants)	May 20-June 4, 2016/ DRC	To continue providing training programs for PT services for women seeking fistula repair services at Panzi Hospital
Elizabeth Arlotti Parish Maimouna Toliver Lauren Bellhouse	May 22-28, 2016/ Nigeria	Provide technical assistance for the development of gender training activities for year 4 workplan.
Judith Goh (consultant)	May 28-June 10, 2016/ Uganda	To provide POP integration into fistula services
Blanka Homolova	June 5-18, 2016/ Uganda	To provide TA support for Site Walk Through, support FY 16/17 workplan development and finalize youth engagement component of objective 2
Lauri Romanzi	July 4-10, 2016/ Uganda	To attend Uganda partners' meeting and provide project management visit in selected sites
Isaac Achwal	July 31-Aug 10, 2016/ Uganda	To provide TA in clinical monitoring and orient the new Clinical Associate to the process
Blanka Homolova Altine Diop	July 31-Aug 13, 2016/ Niger	To provide TA support in evaluating the Site Walk Through process in Tahoua and Maradi sites
Lauren Bellhouse Bethany Cole	Aug 20-Sept 2, 2016/ DRC	To attend DRC partners' meeting, visit two sites, review and re-negotiate subaward contracts, and follow up on gender programming
Shannon Rauh	Sept 25-30, 2016/ Uganda	To develop, with input from Uganda team, participatory sexual and reproductive health education modules and conduct a two-day training to strengthen teachers' capacity with the skills, knowledge and confidence they need to deliver sexual and reproductive health effectively to youth.

Meetings

FC+ global staff convened, attended and presented at numerous meetings throughout FY 15/16, as noted above and summarized in Table 4.

Table 4: Meetings and Presentations, FY 15/16

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Prolapse Integration Workshop	September 29 – October 2, 2015/ New York	Yes	See FY 14/15 Annual Report	See FY 14/15 Annual Report
Malawi and Senegal: Integrated Service Delivery Strategies	September 30, 2015/ Webinar (remote access)	No	Karen Levin	Participation
FIGO World Conference of Gynecology and Obstetrics	October 5-9, 2015/ Vancouver	No	Bethany Cole Lauri Romanzi Joseph Ruminjo Isaac Achwal SK Nazmul Huda Christine Amisi Adamu Isah Habib Sadauki Molly Tumusiime Simon Ndizeye Michel Mpunga	Participation, Presentations (see Appendix D)
Customizing DHIS2 for iNGOs – Part II	October 13, 2016/ Webinar (remote access)	No	Karen Levin	Participation
BGH M&E Working Group	October 29, 2015/ Washington DC	No	Lauren Bellhouse	Participation
PanAfrican Association of Urology Surgeons Conference	November 2015/ Kinshasa, DRC	No	Alexandre Delamou	Presentation
Roundtable on Sexual and Reproductive Health among Adolescents and Young People	September 28, 2015/ Kinshasa, DRC	No	Dolores Nembunzu	Participation
2015 Global Maternal and Newborn Health Conference	October 18-21, 2015/ Mexico City	No	Vandana Tripathi SK Nazmul Huda Lauri Romanzi Joseph Ruminjo	FC+ organized, moderated (LR) and presented (SKNH) at panel on iatrogenic fistula, Presentation (VT) on approaches to measuring QoC in Maternal and Newborn Care services
G4 Alliance Board Meeting and Annual Meeting of College of Surgeons of East, Central and Southern Africa (COSECSA)	November 26-December 5, 2015/ Blantyre, Malawi	No	Lauri Romanzi	Participation
Transforming Gender Norms: Innovative	December 1, 2015/ Webinar (remote access)	No	Lauren Bellhouse	Participation

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Approaches to Working with Men and Boys for Better RMNCH (Webinar)				
USAID PRH SDI CAs	December 8, 2015/ Washington DC	No	Vandana Tripathi	Participation, discussion of total market approach (TMA) in FC+
WHO Global Initiative for Emergency and Essential Surgical Care (GIEESC) meeting and celebration	December 13-15, 2015/ Geneva	No	Lauri Romanzi	Participation and networking with WHO SRH and MNCH staff
Operation Fistula Strategy Meeting	December 16-19, 2015/ London	No	Lauri Romanzi	Participation
USAID PRH Gender CAs meeting	January 19, 2016/ Washington DC	No	Lauri Romanzi	Participation
USAID training on rules and regulations for cooperative agreements	February 1-3, 2016	No	Lauren Bellhouse	Participation
SBCC Summit	February 8-10, 2016/ Addis Ababa	No	Vandana Tripathi Bethany Cole Lauren Bellhouse Amina Bala Molly Tumusiime Issoufou Balarabe Blanka Homolova Elizabeth Arlotti-Parish Eberechukwu Okeke Aboubacar Garba Nitta Biswas Roger Buhendwa Kakule Sophonie	Participation
FC+ SBCC/ Objective 2 Experts' Meeting	February 11-12, 2016/ Addis Ababa	Yes	See Appendix F	Presentations, facilitation See Appendix E
HC3 SBCC Meeting on Service Delivery Programs	February 16-17, 2016/ Washington DC	No	Lauren Bellhouse	Participation
Labour Ward Project	February 28-March 4, 2016/ London	No	Lauri Romanzi	Participation
"What do Men Have to Do With It? An Update on Vasectomy Trends and Program Successes" by the Vasectomy Working Group	March 1, 2016/ Webinar (remote access)	No	Anna Wadsworth	Participation

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
and Johns Hopkins CCP.				
G4 Alliance: Developing a platform to collect surgical care and operative case log data	March 4, 2016/ Webinar (remote access)	No	Karen Levin	Participation
Using ICT Approaches to Generate Demand for RMNCAH	March 9, 2016/ Webinar (remote access)	No	Lauren Bellhouse	Participation
Gender Norms Transformation Across the Lifecourse	March 10, 2016/ Webinar (remote access)	No	Lauren Bellhouse	Participation
12th International Congress on AIDS in Asia and The Pacific	March 12-14, 2016/ Dhaka, Bangladesh	No	Nitta Biswas	Presentation of poster on "Post Repair FP Needs of Female Genital Fistula Cases in Bangladesh"
UNFPA-UNICEF Launch of Global Joint Programme for Acceleration to End Child Marriage	March 15, 2016/ New York	No	Lauren Bellhouse	Participation
What Does Empowerment of Disabled Women Mean Globally?	March 24, 2016/ New York	No	Lauren Bellhouse	Participation
Population Association of America Annual Meeting	March 31- April 2, 2016/ Washington DC	No	Lindsay Mallick (DHS Program)	Poster co-authored with DHS Program: "Fistula and its association with sexual violence and maternal health indicators"
UroDak Workshop	March 31 – April 2, 2016/ Dakar	No	FC+ sponsored surgeons from DRC, Uganda, Niger, Nigeria, Mozambique	Participation
4th Meeting of the Consortium of Universities for Global Health	April 9, 2016/ San Francisco	No	Lauri Romanzi	Participation
MHTF: Performance Based Incentives in Maternal Newborn Health	April 20-21, 2016/ Boston	No	Bethany Cole	Participation
Global Health Partnerships: Innovations in Surgery, Education and Research, 2016. Royal College of Surgeons in Ireland (RCSI)	April 21-22, 2016/ Dublin	No	Vandana Tripathi Adamu Isah	Emerging evidence from FC+ sites/partners about iatrogenic fistula (oral presentation). Preliminary findings on demand and capacity for the integration of pelvic organ prolapse (POP) services at fistula treatment sites (poster).
Women Deliver	May 16-20, 2016/ Copenhagen	No	Bethany Cole Lauren Bellhouse	Hosted session on maternal and newborn morbidities

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
			Lauri Romanzi	Hosted breakfast event on global surgery in collaboration with G4 Alliance and GE Foundation. https://fistulacare.org/blog/2016/05/women-deliver/
Maternal peripartum infection – WHO recommendations, prevention and treatment of maternal peripartum infections	May 17, 2016/ Webinar (remote access)	No	Isaac Achwal	Participation
G4 Alliance Board Meeting/ 69th World Health Assembly	May 20-24, 2016/ Geneva	No	Lauri Romanzi	Participation
EngenderHealth CDDM Meeting	June 6-11, 2016/ Addis Ababa	No	Hena Baroi Aboubacar Garba Mai Birni Abiodun Amodu Joseph Ringpon Gwamzhi Hassan Kanakulya Paul Muwanguzi Karen Levin	Presentations, Participation See Appendix G
FC+ One-Day Check In	June 12, 2016/ Addis Ababa	Yes	Hena Baroi Aboubacar Garba Mai Birni Abiodun Amodu Joseph Ringpon Gwamzhi Hassan Kanakulya Paul Muwanguzi Karen Levin	Presentations, Participation, Organization See Appendix H
Implementing the WHO Safe Birth Checklist	June 15, 2016/ New York	No	Lauren Bellhouse	Participation
Forum on Public-Private Partnerships for Global Health and Safety Engaging the Private Sector and Developing Partnerships to Advance Health and the Sustainable Development Goals – A Workshop	June 23, 2016/ New York	No	Bethany Cole	Participation
DHIS2 Community Meet-Up	July 12, 2016/ Washington DC	No	Karen Levin	Participation
After Copenhagen: What's Next for Women and Girls	July 18, 2016/ Washington DC	No	Lauren Bellhouse	

Meeting	Dates/Location	Convened by FC+?	Attending	FC+ Inputs / Presentations
Restoring dignity: UNFPA's work to end fistula	July 27, 2016/ Webinar (remote access)	No	Lauren Bellhouse Karen Levin	Participation
A Call to Action to Address Iatrogenic Fistula	August 17, 2016/ Webinar (NY and remote access)	Yes	Lauri Romanzi Bethany Cole Vandana Tripathi	Organization, presentation, moderation
Mid Term Evaluation Debrief for Fistula Care *Plus*	September 8, 2016/ Washington DC	No	Vandana Tripathi Lauri Romanzi Bethany Cole	Participation
Lancet Maternal Health Series Global Launch	September 18, 2016/New York	No	Lauri Romanzi Vandana Tripathi Elly Arnoff	Participation
SDI CAs Meeting	September 21, 2016/ Washington DC (remote access)	No	Vandana Tripathi	Participation
Making the Pitch: DHIS2 for NGO Evaluation	September 22, 2016/ Webinar (remote access)	No	Karen Levin	Participation
Bloomberg Data for Good Exchange 2016	September 25, 2015/New York	No	Vandana Tripathi	Participation

Funding

The FC+ project was awarded on December 12, 2013 with a ceiling of $74,490,086.

Of the total FY 13/14 funding of $7.36M, $3.9M (53%) was obligated in December 2013 and the balance of $3.46M (47%) was obligated in May 2014. The late obligations of field support funding in FY 13/14 resulted in delays for subawards relating to fistula treatment, most of which could not be put in place until the first quarter of FY 14/15.

In FY 14/15, $6.13M (63%) was received in November 2014, $1.84M (19%) was received in March 2015, $1.1M (11%) in May 2015 and $0.7M (7%) in September 2015 to bring the total FY 14/15 obligations to $9.77M. During FY 14/15, funding for several countries was delayed six or more months: DRC funding and West Africa PRH funding was received in March 2015 while Uganda funding was received in May 2015. As a result of these delays, FC+ operated with significant cost overruns in the respective funding streams.

In FY 15/16, $8.2M funding has been received ($7.7M in January 2016 and $500K in April 2016). The late obligations of field support funding in FY 15/16 resulted in delays in the processing of subawards relating to fistula treatment and also required the project to keep a very robust pipeline which jeopardizes timely implementation of activities. Cumulative expenditures and subaward commitments (see Table 2) as of September 30, 2016 are projected to be $23.7M, leaving an obligated pipeline of $1.6M.

SECTION II: GLOBAL ACCOMPLISHMENTS

Fistula Care *Plus* Achievements

In the third fiscal year, FC+ made significant achievements in line with the aims and targets of its global workplan. The obligation delays described in Section I above delayed implementation of new subawards, which in turn constrained some project activities.

Table 5 provides a snapshot of FC+ achievements in FY 15/16. Full reporting on FC+ benchmarks for core indicators is updated annually and included in Appendix V of this annual report. Appendix I provides information on all USAID-supported fistula repair surgeries from 2005-present.

Table 5: Select Fistula Care Plus Achievements and Benchmarks as of September 30, 2016

	FY13/14 Actual	FY14/15 Actual	FY15/16 Planned	FY15/16 Actual
Number of countries supported by FC+	5	6	6	6
Number of sites supported by FC+ for fistula repair and prevention	25	31	35	37
Number of prevention-only sites supported by FC+	16	249 500 former TSHIP	290 500 former TSHIP	289 500 former TSHIP
Number of participants in community volunteer/educator training in tools and approaches to raise awareness regarding fistula prevention and repair	114	776	607	679
Number of community awareness-raising activities/events conducted by program partners	12	1,990	1,695	10,352 (in person) 41 (mass media)
Number of participants reached through community awareness-raising events/activities conducted by program partners	10,745	414,067	306,750 (in person) 1,550,000 (mass media)	2,862,124 (in person) 3,676,406 (mass media)
Number of fistula repairs	873	2,876	4,121	3,514
Number of participants in health systems personnel training, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider)[1]	161	1,065	1,395	1,414
Number of FP counseling sessions provided	38,373	149,610	204,532	167,424 (FC+) 198,614 (Former TSHIP)
Number of CYP provided	40,039	107,986	153,261	106,645 (FC+) 89,341 (Former TSHIP)

[1] This does not include training of surgeons to provide fistula repair.

Clinical training is one of the key mechanisms by which FC+ advances project aims across objectives; clinical training outputs are summarized in Table 6. Training accomplishments are described in greater detail in Objective 4, and in Section III, by country. With USAID bilateral support, Pathfinder also carried out training in Ethiopia for 1,321 health providers, focusing on fistula identification and referral, and IntraHealth trained 1,284 health providers in quality assurance, surgical skills for fistula repair, data for decision making and fistula prevention topics.

Table 6: Total Number of Clinical Training Participants, by Country, by Topic, FY 15/16

	Bangladesh	DRC	WA/Niger	Nigeria	Uganda	WA/Togo	Total
First Training in Surgical Fistula Repair	5	1	0	4	0	0	**10**
Continuing Training in Surgical Fistula Repair	1	2	0	3	0	0	**6**
ANC	0	0	0	0	0	0	**0**
Community, outreach and advocacy	0	0	15	0	57	0	**72**
Data management	0	0	0	83	40	0	**123**
EmONC	0	32	0	0	2	0	**34**
EmONC and labor monitoring	0	140	40	0	93	0	**273**
FP counseling	0	0	0	170	0	0	**170**
FP methods	0	0	0	72	0	0	**72**
FP and fistula counseling	12	0	0	0	0	0	**12**
Fistula counseling	0	0	0	0	10	9	**19**
Gender	0	0	0	0	0	0	**0**
Infection Prevention	40	48	20	31	190	0	**329**
Non-surgical POP treatment	0	0	0	0	30	0	**30**
Pre- and Post-Operative Care	31	14	0	72	40	0	**157**
Quality Assurance	0	0	18	58	0	0	**76**
Other	0	0	0	47	0	0	**47**
TOTAL	**89**	**237**	**93**	**540**	**462**	**9**	**1,430**

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+ strengthens the enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors by improving country and facility policies, guidelines, and resources allocated to fistula prevention and treatment, including addressing the needs of particularly vulnerable women (e.g., women deemed incurable (WDI) and those with traumatic fistula (TF)).

Sub-Objective 1.1: Establish sustainability plans: from policy to implementation

FC+ continues to monitor the landscape for opportunities to develop public private partnerships. During FY 15/16, FC+ global team members have begun cultivating a Sustainable Development Goal (SDG)-based approach, with engagement of the private and academic sectors. In addition to academic and professional organizations, FC+ reached out to medical device companies to explore potential markets and joint ventures. These meetings included anesthesia machines and

other medical devices related to pelvic floor rehabilitation services. Additionally, several workshops were held with Seth Cochran of Operation Fistula to explore potential partnerships.

At the end of March, 2016, global staff met with physical therapy consultants Jessica McKinney and Laura Keyser, and with Peter Bulla, Global Development Manager of LABORIE, a urodynamics and pelvic floor physical therapy company with emerging interest in pessary supply chain strengthening in sub-Saharan Africa. McKinney and Keyser have made two trips to DRC in FY 15/16 to work with Panzi Hospital on development of a pelvic floor physical therapy (PFPT) program. FC+ is working together with them to expand this program into West Africa, most likely Nigeria, in FY 16/17. McKinney and Keyser will execute a site visit to Abakaliki VVF Center after the biennial ISOFS meeting in Abuja, in October 2016, to begin to frame out the expansion of pelvic floor physical therapy at this pelvic organ prolapse (POP) integration site in Nigeria. In addition, FC+ worked with LABORIE to plan a half-day urodynamics workshop at the upcoming ISOFS meeting in October 2016 in Abuja, Nigeria.

In May 2016, global staff met with Joanna Pozen, co-founder of Restore Cup: a corporation that has developed a silicone cup for women with fistula to combat leaking and incontinence. The patent is pending, but the design is based that used for menstrual cups. The company is in the early stages of research and development (R&D) and interested in identifying partners for research, collaboration and distribution. FC+ intends to continue discussion with the company as it moves forward in the R&D process.

In September 2016, the Project Director met with several institutions in London to further FC+'s sustainability and legacy platform. This included discussions with the Royal College of Obstetricians and Gynecologists (RCOG) to leverage project activity through negotiations with the RCOG Global Health Division, as well as FIGO, UNFPA and ISOFS, to support the drafting of a training manual for evaluation and surgical and nonsurgical treatment of fistula, POP, incontinence and related pelvic floor disorders. FC+ is also working with RCOG to support its ongoing work with university Ob-Gyn programs in sub-Saharan Africa. These programs are launching credentialed urogynecology or Female Pelvic Medicine (FPM) fellowship programs to develop short-course FPM Certification programs for fistula surgeons who are medical officers that, while not eligible for full FPM fellowship training, have earned the support of the academic community towards creating pathways for career advancement through training and certification programs.

To further this, FC+ is convening a working group to compile a modular training manual for FPM. The manual will be designed to support academic, credentialed urogynecology and female pelvic medicine fellowships emerging in sub-Saharan Africa (Ghana, Nigeria, Ethiopia) and South Asia (Nepal, Bangladesh), all of which were founded by senior fistula surgeons working in renowned fistula facilities. FC+ has invited RCOG, UNFPA, FIGO and regional sub-Saharan Africa and South Asia professional organizations to be part of this working group.

To explore potential collaboration in countries with overlapping operation, the Project Director also met with The Global Alliance for Improved Nutrition (GAIN), an international organization

that was launched at the United Nations in 2002 to tackle the human suffering caused by malnutrition. GAIN works with governments, civil society, businesses, UN agencies, and academic institutions to develop programs that deliver large-scale and locally relevant solutions to malnutrition in more than 30 countries. Consistent with the outreach strategy of FC+, GAIN has recently expanded their approach to reach those on the margins of society, who are often the most excluded, vulnerable and severely malnourished.

Beginning in the final year of the prior Fistula Care Project through the first three years of FC+, the project worked with the Nigeria Federal Ministry of Health (FMOH) and convened meetings and discussions to develop a national policy and guidance on the use of catheterization to prevent and conservatively treat fistula, reducing the need for surgery. In March 2016, the draft guideline, developed through meetings and discussions convened by FC+, was approved by the FMOH. The guideline will formally be launched at the ISOFS conference in Abuja, Nigeria in October 2016.

In FY 15/16, FC+ strategized for advocacy and participation in the renewals of the National Fistula Policy in Uganda and the next iteration of the National Fistula Strategy in Nigeria, both of which will end in 2016.

FC+ recognizes the lack of surgical safety and quality assurance across fistula care facilities in low-income countries (where the prevalence of fistula is higher). There is an unsafe surgical culture at many facilities, and staff attitudes and perceptions serve as barriers to the utilization of safety checklists and reporting. To address this, FC+ has commissioned Medical Aid Films (MAF) to create a 20-minute orientation video to complement the formal roll-out of the FC+ Surgical Safety Toolkit during the first half of FY 16/17 (see Obj. 4 for more information on the Toolkit).

In addition to FC+ activities in DRC and Uganda, EngenderHealth is implementing ExpandFP, a two year, $3 million Bill and Melinda Gates Foundation (BMGF) funded project. This FP project focuses on increasing sustainable access to quality hormonal implant services in a context of informed choice and volunteerism in Tanzania, DRC, and Uganda with a focus on training and support for providers.

The FC+ Global Projects Manager took part in several activities during the fiscal year to advance project development of public private partnerships (PPP). These included attendance at a two-day Forum on PPPs, scanning of booths at the Women Deliver conference for potential collaborations, and conducting a project-wide survey of anesthesia machines in supported fistula facilities as part of on-going discussions with Gradian Health Systems (www.gradianhealth.org).

The PPP forum, entitled: “Global Health and Safety Engaging the Private Sector and Developing Partnerships to Advance Health and the Sustainable Development Goals,” was held to move toward an actionable framework for engaging the private sector and developing partnerships to advance health-focused sustainable development priorities at the country level. This forum was a

top level discussion on tactical, multi-platform partnerships that include governments and large business[2].

While at the Women Deliver conference, 120 booths present were scanned for potential partnerships. Three booths - Dignity Dreams, Simavi, and Be Girl - showcased pads or underwear products that could be used by women with fistula. As part of continuing conversation with Gradian Health, an anesthesia machine survey was sent to all partner repair sites. Results will be used to strengthen anesthesia services as part of safe surgery and the project will play a catalytic role between Gradian, the existing distribution network, partner sites, and government agencies where possible.

At the country level, FC+ teams continue to maintain and expand partnerships with private entities, such as media outlets, for cost share and other support to FC+ activities. See Section III, by country.

Sub-Objective 1.2: Improve data available on OF to facilitate planning

FC+ has carried out several activities during FY 15/16 to promote the availability of improved data about fistula. In collaboration with USAID/W, the launch of the Fistula Community of Practice (FCoP) took place in May 2016. The purpose of the FCoP is to facilitate collective learning, knowledge sharing, coordination, and technical resource development related to preventive care, detection, treatment, and reintegration support for women and their families and communities and to leverage that within the global conversation and activity around fistula. FCoP membership is extended to USAID Missions and organizations funded to work on fistula. FC+ will provide global leadership through the FCoP for sharing lessons learned and convening meetings for technical exchange. The first FCoP event, a webinar on clinical and M&E data collected by FC+ regarding iatrogenic fistula, was held on August 17, 2016, with 122 registrants from around the world.

At the 2014 FC+ International Research Advisory Group (IRAG) meeting, participants judged it important to work toward improved methods for the measurement of fistula incidence and prevalence. Advisors at a linked consultation on measurement and estimation agreed that FC+ should develop an inventory of tools that have been used to identify fistula cases in recent studies and surveys, map the content of question topics and wording in these tools, and conduct a study to develop and validate a non-clinical diagnostic interview/survey tool. The inventory of tools was conducted in FY 14/15. The Deputy Director shared tools and findings from this inventory with the USAID/Bangladesh supported team developing the Bangladesh Maternal Mortality and Morbidity Survey (BMMMS). FC+ has advocated with the BMMMS team to incorporate fistula and POP in the survey, and has been providing ongoing technical assistance for a clinical

[2] Workshop report found here: http://www.nationalacademies.org/hmd/Activities/Global/PublicPrivatePartnershipsForum/2015-DEC-3.aspx?utm_source=HMD+Email+List&utm_campaign=8fee13c998-07_19_16_BGH_PPP_Forum_Jul_Newsletter&utm_medium=email&utm_term=0_211686812e-8fee13c998-180491865

validation study to evaluate the sensitivity and specificity of a questionnaire to screen for fistula and POP cases. This TA has included support for the development of a morbidity module for the BMMMS and for protocol development for a clinical validation sub-study (see Objective 5). This support comes at the request of USAID/Bangladesh. FC+/Bangladesh will coordinate clinical exams of suspected fistula cases identified through this sub-study and refer them for care, in partnership with the MaMoni project in Bangladesh.

Following an FC+-commissioned secondary analysis of fistula data from the Demographic and Health Surveys (DHS), FC+ has co-authored a manuscript summarizing findings, see Objective 5 for details.

FC+ had planned to continue work with partner UNFPA to finalize materials related to 12 indicators that had been selected as "super-core" indicators for fistula programming, addressing prevention, treatment, and reintegration. The aim of the workshop had been to bring together the actors involved in developing these indicators (USAID, CDC, UNFPA, AMDD, and FC/FC+) to endorse a common definition and measures for these 12 "super-core" indicators. It has proven difficult to coordinate such a workshop with our co-host, UNFPA; due to human resource and time limitations. Given the significant advancement of the body of knowledge around fistula indicators (e.g., adoption of FC+-recommended fistula indicators in several HMIS), the value of the indicators as a workplan priority has diminished. Therefore, with USAID approval, FC+ will no longer devote resources to the indicators workshop and materials. However, FC+ will develop a brief summarizing partners' work on the indicators and present a synthesis of this activity at the ISOFS conference in October 2016.

Sub-Objective 1.3: Advocate for a fistula-free generation

Activities to strengthen the enabling environment for fistula services and advocate for prevention and treatment needed to achieve a fistula-free generation have been taking place across countries throughout the fiscal year. National working groups have been meeting with FC+ support and participation in Bangladesh, DRC, Uganda and West Africa Region/Niger, to revise and update national strategies for the elimination of fistula.

In the first quarter of FY 15/16, FC+ carried out a review of the landscape of national strategies for obstetric fistula prevention and treatment. This comprehensive review details strategies in ten countries, describing them and categorizing whether they contain various key elements including FP, reintegration, and WDI. Identified gaps in these key elements will focus FC+ efforts towards uniform engagement towards adoption of national strategies that include (but are not limited to) FP for fistula prevention, post-treatment fistula reintegration and WDI programming, as well as MoH budget lines to support the national strategies. A summary table from the document can be found in Appendix J. The report was shared with country teams; in FY 16/17, the findings will guide advocacy for improved policy with national working groups and ministries.

FC+ joined UNFPA and other key partners in commemorating the International Day to End Obstetric Fistula (IDEOF). IDEOF creates an opportunity to further dialogue and intensify action

within the international community to end all fistula. In the lead-up to 23 May, each country program coordinates a series of national and local media spots, hosts stakeholder meetings, and ramps up fistula prevention and treatment efforts (see Appendix U for details from across the project). Across all supported countries during the 2016 commemorations, FC+ was able to:

- Appear in at least **16** newspaper or online print media sources;
- Participate in at least **43** radio programs;
- Participate in at least **four** television programs;
- Host at least **19** local, national, or international events ranging from parades to panels at international conferences.

This project year, two large events in the public health arena coincided with the lead-up to IDEOF: the 69th World Health Assembly (WHA) and the Women Deliver conference, held May 16-19 in Copenhagen, Denmark. The FC+ Project Director attended WHA as a delegate alongside the G4 Alliance. Dr. Romanzi also participated in a global surgery event held in Geneva on 23 May.

FC+ coordinated two events at the Women Deliver conference:

- A concurrent session, "*The Forgotten Challenge: Maternal and Newborn Morbidity*." The panel featured a midwife from Bangladesh, a professor of obstetrics and gynecology from Burkina Faso, a newborn morbidity researcher from the UK, and the FC+ project director. During the question-and-answer portion of the panel, Erin Anastasi of the UNFPA Campaign to End Fistula publicly announced the theme for this year's International Day to End Obstetric Fistula- "End Fistula Within a Generation."

Participants during the FC+-led maternal and newborn morbidity panel at Women Deliver. Credit: L. Bellhouse

- A side event titled *Safe Surgery: A Non-Negotiable for Women's Health, Equity, and Wellbeing?*, held in partnership with GE Foundation, the G4 Alliance, and Safe Surgery 2020. The breakfast event featured Dr. Denis Mukwege of Panzi Hospital, Erin Anastasi of the UNFPA Campaign to End Fistula, Dr. Luc de Bernis, formerly of UNFPA, and FC+ Director Lauri Romanzi, who explored the intersection of safe surgical care and women's well-being, economic productivity, and equality.

FC+ partnered with professional organizations and other actors in the international maternal and child health community to plan and carry out advocacy efforts towards the eradication of fistula. FC+ continues our work with the Global Alliance for Surgical, Obstetric, Trauma, and Anesthesia Care (G4 Alliance www.g4alliance.org). The G4 Alliance was formed in response to

growing recognition of the global burden of surgical disease and related costs in low- and middle-income countries. Both the G4 Alliance and the Lancet Commission agendas include specific focus on access to surgical FP services, timely C-section delivery, prevention and treatment of genital fistula, and access to effective treatment for POP, all executed at or above minimum acceptable standards of care.

By participating in this advocacy alliance, FC+ works to bring a FP, reproductive health, and integrated maternal morbidity treatment perspective to the global surgical movement, and to support improved platforms of surgical capacity for the delivery of related services. FC+ is serving on the G4 Alliance Interim Board of Directors. During FY 15/16, FC+ provided technical guidance to the G4 Alliance related to DHIS2 and indicator development, as part of their ongoing efforts to develop a platform to collect surgical data across low- and middle-income countries.

In May 2016, the Project Director attended the G4 Alliance Board meeting in Geneva, held concurrently with the 69th Annual World Health Assembly. The governance of the Alliance is changing to accommodate a permanent board with limited seats that require nomination. The permanent council will be populated by all member organizations with one seat each. EngenderHealth now serves as co-chair of the standards working group, participates on the membership committee, and continues to advise the working groups for Targets and Indicators. The G4 Alliance held a Safe Surgery event on May 23 (IDEOF) which sent a powerful message about the importance of including surgery, anesthesia, obstetrics and trauma care in global health.

The EngenderHealth Senior Clinical Advisor from Ethiopia and the FC+ Program Director from Uganda were chosen to participate as EH representatives to the G4 Alliance. Through this leadership role, FC+ is also facilitating an initiative to launch participation of reproductive health surgeons in the membership of the College of Surgeons of East, Central and Southern Africa (COSECSA, www.cosecsa.org), an organization that is eager to include ECSA region obstetrician/gynecologists in eligibility for regional fellowship credentialing.

The FC+ Uganda Country Manager and the Global Project Director participated in a Board Meeting at the COSECSA Annual General Meeting and Scientific Conference in Blantyre, Malawi. In addition to scientific sharing, a graduation ceremony was held for post graduate fellows across a wide range of surgical disciplines that included pediatric surgery, anesthesia, orthopedic, plastic, and general surgery. It was at this conference that ‘a golden’ opportunity of East, Central and Southern Association College of Obstetricians and Gynecologists (ECSACOGS) joining the global surgical community of practice was realized. FC+ continues to support ECSACOGS in a bid to ensure that fellowships for Obstetricians and Gynecologists start and are embraced in COSECSA post graduate fellowships. This initiative is being implemented with the support of the COSECSA Secretary General and G4 Alliance Vice Chairperson, as well as the President of the West African College of Surgeons.

In April 2016, the Deputy Director and the Senior Clinical Advisor of FC+/Nigeria attended the Global Health Partnerships: Innovations in Surgery, Education and Research meeting, convened by the Royal College of Surgeons in Ireland. The meeting was an opportunity for RCSI to showcase its collaboration with the College of Surgeons in East, Central and Southern Africa (COSECSA) and to contextualize this work within the nascent global surgery movement. The meeting also provided an opportunity for participants outside RCSI/COSECSA to highlight how other global partnerships are advancing surgical capacity and services to promote public health, primarily in sub-Saharan Africa. The FC+ Deputy Director presented program data on two topics:

- Emerging evidence from FC+ sites/partners about iatrogenic fistula (oral presentation).
- Preliminary findings on demand and capacity for the integration of POP services at fistula treatment sites (poster).

The full meeting program can be found at the RCSI website: https://www.rcsi.ie/files/newsevents/docs/20160413045122_FINAL%20GHP%2s0programme.pdf

During FY 15/16, FC+ facilitated introductions between the American College of Obstetrics and Gynecology (ACOG) and the Ethiopian Society of Obstetrics and Gynecology (ESOG). Direct follow-up communications between these two entities have resulted in proprietary engagement of ACOG and ESOG towards transformative systems strengthening of ESOG. Given the proprietary nature of the collaboration, details are not available to FC+.

As part of a coordinated external relations strategy, the FC+ blog and Twitter account have been updated regularly throughout FY 15/16. Throughout the year, the blog has featured 17 postings highlighting current issues in maternal health and FC+ activities, authored by FC+ Global Team and country program staff as well as FC+ partners. Overall, the website had a total of 33,471 page views (see Figure 2 for views by month). The FC+ Twitter account metrics are presented in Table 7.

Updated FC+ Website home page.

Additionally, FC+ introduced an updated website interface during year three. The new platform enhances usability while retaining all content from the older website. The new FC+ site adheres to the branding and marketing plan established by USAID and FC+ at the start of the project.

Figure 2. Fistula Care *Plus* Website Views by Month, FY 15/16

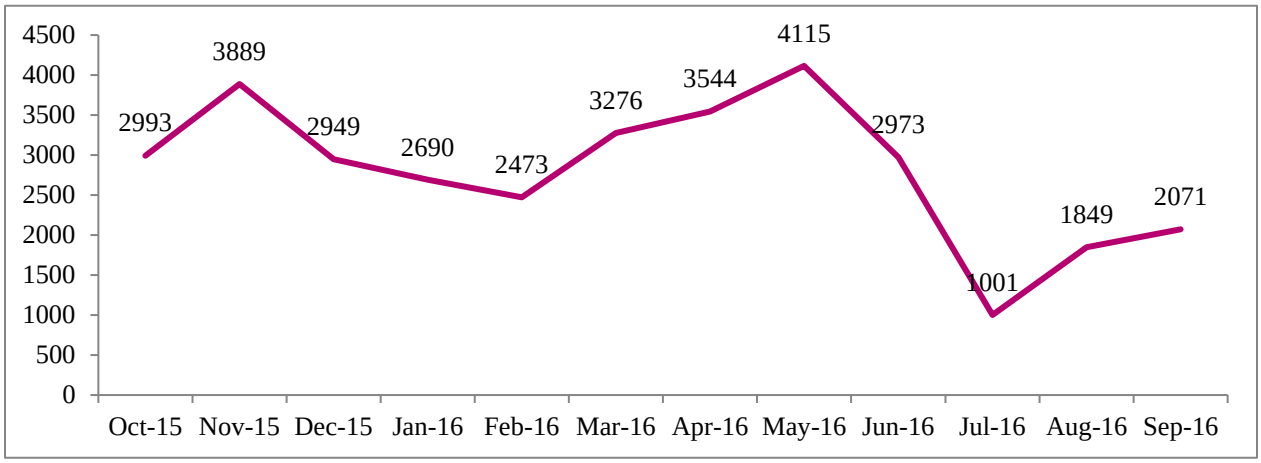


Table 7. FC+ Twitter Account Metrics, FY 15/16

Metric	Value
Twitter Followers	463 (an increase of 127% from previous period)
Impressions ("number of times tweets appear on feeds")	137,260
Link clicks	209
Retweets	446
Favorites/Likes	440
Mentions	267 (an increase of 53% from previous period)
Total Engagements ('the number of times someone interacted with a tweet')	1,747 (an increase of 78% since previous period)

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+ enhances community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula by building community awareness, skills, and mobilization regarding the behaviors and services that can prevent fistula, as well as those that enable treatment.

FC+, through its year three workplanning process, identified the need for more coordination of approaches and activities around Objective 2. As a result, a workshop to structure thinking around the project's social and behavior change communication (SBCC) and community engagement (CE) activities was planned. This workshop was held just after the USAID-sponsored SBCC Summit (http://sbccsummit.org/) in Addis Ababa, Ethiopia in February 2016. Each FC+ country office was asked to identify the team member working in SBCC and CE to attend the Summit and FC+ workshop who could discuss SBCC and CE approaches used and successes and failures on the FC+ project. This workshop also included guest speaker Habiba Corodhia Mohamed from Fistula Foundation who shared client identification activities in rural Kenya.

At the workshop, presentation discussed CE strategies, gender orientation, and indicators for SBCC and outreach activities. The team decided on six priority behaviors that the project would target in CE and SBCC work: 1) women suffering from fistula seek treatment from an accredited fistula treatment center; 2) women make positive decisions to enact their own reproductive intentions; 3) health care workers interact respectfully with their clients; 4) pregnant women deliver using a skilled birth attendant with timely access to EmONC; 5) pregnant women attend a minimum of four ANC sessions; and 6) community and religious leaders promote the use of SRH/MCH services. The agenda and participants list can be found in Appendix E and F.

The FC+ project aims to deliberately address gender inequalities in order to maximize its overall impact. Through gender integration - the process of applying a gender strategy to program design and implementation - FC+ aims to address underlying causes of fistula that are linked to gender inequality and respond to negative gender attitudes and norms that result in barriers to women's access to key health services, such as maternal health care, FP, and timely access to EmONC.[3] Addressing harmful gender attitudes and norms will also help to reduce stigma and increase community support for the successful social reintegration of fistula clients. By integrating gender issues into program implementation, FC+ believes that improving women's access to health services can be part of a process that contributes to women's empowerment, benefiting women and men, their children, and communities at large.

Participants in the Nigeria Gender 101 training complete an activity on gender norms. Credit: L. Bellhouse

FC+ Program Associate Lauren Bellhouse was designated as the Gender Focal Point for the project in FY 14/15. During FY 15/16, the Gender Focal Point, with input from the FC+ Global Team and technical advisors from the EngenderHealth Gender team, developed a Gender Action Plan (see Appendix K) to address the training, capacity, and programmatic needs of the project in its entirety and ensure that it integrates gender where possible. The action plan is based on input from country programs through key informant interviews and feedback shared by country teams during gender-focused workshops, as well as best practices related to gender equitable programing and recommendations from the Gender team. The key recommendations for the action plan fall into three categories: 1) building the capacity of FC+ staff on gender-related issues, 2) ensuring gender-sensitive or -transformative activities across the program, in line with EngenderHealth Gender Standards and Practices (S&Ps), and 3) engaging men as partners and

[3] Population Reference Bureau. Pursuing Gender Equality Inside and Out: Gender mainstreaming in international development organizations. 2015. Available at: http://www.prb.org/pdf15/gender-mainstreaming.pdf

agents of change in the prevention and treatment of fistula. A draft document was shared with USAID, MTE evaluators, and country programs in the fourth quarter of FY 15/16; the final version will be widely shared when available.

Among the main building blocks of internal and external gender capacity building through FC+ are the EngenderHealth Gender 101 workshops. As of the end of FY 15/16, staff from the country programs in Bangladesh (15 staff members), West Africa/Niger (five staff members), Nigeria (20 staff members and 10 CBO partners), and representatives from DRC sub-award sites (three partners) have received Gender 101 training from the FC+ Gender Focal Point and EngenderHealth's Senior Associate for Gender, Maimouna Toliver. Training in Uganda will take place during FY 16/17 and will include additional partners from neighboring DRC to facilitate cross-border learning and experience sharing. From the Gender 101 workshops, each country program develops action items that are monitored and updated with support from the Gender Focal Point.

Additionally, Bangladesh and Nigeria have developed Gender Working Groups within their country offices to carry forward internal capacity building and appropriate gender integration in program activities and messaging. A Gender TOT will be held in FY 16/17 for the Nigeria Gender Working Group based upon their request for further capacity building.

Sub-Objective 2.1 Create awareness and reduce stigma about OF

Country-level activities to increase community understanding and practices related to preventing fistula and the availability of fistula repair services were undertaken in Bangladesh, DRC, West Africa Region/Niger, Nigeria, and Uganda during FY 15/16. A total of 10,393 community outreach/education/advocacy events were carried out, reaching over an estimated 6.5 million people. FC+ has identified the need to break down this number of individuals reached through outreach/education/advocacy events to clarify the number who attended events in person and those who were reached via mass media efforts (i.e. television and radio programming); this is reflected in the PMP revisions described above. FC+ now obtains viewer/listener estimates for mass media outreach whenever possible. 10,352 in-person community activities were supported during the fiscal year, reaching over 2.8 million people. 41 mass media activities were supported, estimated to reach over 3.6 million people. Additional detail by country can be found in Table 8 below, as well as in Section III.

Table 8: Community Outreach/Education Events, by Country, FY 15/16.

Country	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Bangladesh										
-in person	153	3,637	116	1,585	163	2,476	10	248	**442**	**7,946**
-mass media	0	0	0	0	30	980,054	0	0	**30**	**980,024**
DRC										
-in person	14	906	6	2,461	12	1,619	13	383	**45**	**5,369**
-mass media	2	N/A	2	N/A	1	N/A	1	15,000	**6**	**15,000**
WA/Niger										
-in person	1,035	43,731	1,153	41,475	2,699	80,995	2,607	76,215	**7,494**	**242,416**

Country	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
Nigeria -in person	146	87,239	58	27,080	113	9,481	25	26,263	**342**	**150,063**
Uganda -in person -mass media	6 0	34,539 0	2 1	14,635 645,395	467 1	12,593 724,599	1,554 3	44,545 3,661,406	**2029 5**	**106,312 5,031,400**
Total	**1,356**	**170,052**	**1,338**	**732,631**	**3,486**	**1,811,787**	**4,213**	**3,824,060**	**10,393**	**6,538,530**
-in person -mass media	**1,354 2**	**170,052 N/A**	**1,335 3**	**87,236 645,395**	**3,454 32**	**107,164 1,704,623**	**4,209 4**	**147,654 3,676,406**	**10,352 41**	**2,862,124 3,676,406**

Additionally, a total of 679 community volunteers and educators were trained in Bangladesh, DRC, West Africa Region/Niger and Nigeria during FY 15/16. Participants included cured fistula patients, community partners and local religious leaders; see Table 9 and Section III, by country, for more information. In the first half of the project, emphasis has been on the identification and training of community volunteers. This has enabled efforts in FY 15/16 and onward to shift focus from training towards increased outreach activity in communities and with media, community structures, and religious institutions.

Table 9: Community Volunteer/Educator Training, Participants by Country, FY 15/16.

Country	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
Bangladesh	30	0	8	10	**48**
DRC	3	0	0	0	**3**
WA/Niger	54	0	360	0	**414**
Nigeria	0	54	160	0	**214**
Total	**87**	**54**	**528**	**10**	**679**

Sub-Objective 2.2 Establish partnerships to facilitate achievable, holistic goals for reintegration to meet the needs of women with fistula

Global staff provided technical and management input to the subawards development process for all countries; including support to TERREWODE, a resource partner on the FC+ project, for the development of a scope of work specifically targeting WDI. This subaward began in FY 14/15 and the partnership will be continued through PSAs in FY 15/16. A major collaboration activity is a study to understand the needs of WDI as well as the effects of social reintegration services for this group. The study has received IRB approval and begun implementation, see Objective 5 and Section III for additional details.

FC+ has also developed a partnership with UCSF/Makerere University to provide support for a study on reintegration after fistula repair in Uganda, see Objective 5 for additional detail.

As described in Objective 1, potential PPPs FC+ is exploring may increase access to products that can help women with fistula, particularly WDI, better integrate into the community by mitigating the impact of their symptoms.

Objective 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

Efforts to reduce transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support target the challenges that keep women from being able to access and use fistula services, particularly for repair, and will involve testing innovative incentives and enablers to help women overcome these obstacles.

Sub-Objective 3.1 Reduce transportation barriers for prevention and treatment of Sub-Objective 3.3 Reduce financial barriers to fistula prevention, treatment, and reintegration

During FY 15/16, the Population Council, FC+ implementing partner, conducted formative research on barriers to obstetric fistula treatment in Uganda and Nigeria. This qualitative research included Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) with a range of informants from communities in the four study sites in Nigeria and Uganda.

Research reports on the findings from the formative research on assessing barriers to fistula care and treatment in Nigeria and Uganda were completed by the Population Council, reviewed by FC+ and USAID, and approved in March 2016. Technical briefs of the formative research study findings were published in August (Uganda) and September (Nigeria) 2016, and are available on both the FC+ and Population Council websites (http://www.popcouncil.org/research/fistula-care-plus).

Based on the research findings and with guidance from the Population Council, the FC+ global and Nigeria/Uganda teams developed an intervention package to reduce key barriers faced by women in Nigeria and Uganda. Population Council has developed a protocol for the intervention research study to evaluate the effectiveness of this package in increasing access to quality fistula repair services, and evaluate whether different outreach or access improvement strategies are in fact reaching the women who most need support. Additionally, Population Council is developing and validating a "fistula barriers index" – a brief tool that can be used to assess the challenges faced by women in accessing fistula care. Population Council has begun baseline data collection in Nigeria and Uganda.

The intervention to be tested targets barriers related to stigma, low awareness, cost of transport, and gatekeeping by providers at lower-level facilities. It combines multiple SBCC channels (community agents, primary health center workers, and mass media) with a single fistula screening algorithm, a fistula screening hotline, and vouchers to support transportation costs. The intervention will be implemented in Ebonyi State in Nigeria with the National Fistula Centre at Abakaliki Hospital as the treatment site, in Katsina State in Nigeria with the National Fistula Centre at Babbar Ruga Hospital as the treatment site, and in Kalungu District in Uganda with Kitovu Mission Hospital as the treatment site.

A cornerstone of the intervention is an interactive voice response (IVR) hotline that eliminates gatekeepers to fistula screening and referral, as well as ensures access for women who may not

access face-to-face outreach and screening due to stigma. VOTO Mobile (votomobile.org) is the partner implementing the IVR hotline; VOTO was selected after a careful review of potential mHealth partners, and has greater experience than any other vendor in implementing health information, screening, and mobilization interventions through voice-based mobile communication. A PSA with VOTO was developed in the third quarter.

Sub-Objective 3.2 Improve communication in support of fistula prevention, treatment, and reintegration

During FY 15/16, the Deputy Director continued to provide technical guidance to Nigeria staff in conducting a communications assessment, including development of a qualitative research curriculum for research assistants, a manual of operations, and a data analysis codebook. This curriculum is transferrable to other qualitative research studies conducted by FC+, EH, and other partners. The in-country research team received training for study implementation and study data was collected in the first half of the fiscal year. The FC+ Deputy Director trained a qualitative data analysis team at HQ, and data analysis using Atlas.ti software began took place in the second and third quarters. Qualitative data analysis and an initial summary of the findings were completed in the third quarter. Two draft reports of the communications study findings (one focused on quantitative data, the other on qualitative) were prepared in the fourth quarter of FY 15/16, and have been shared with the Nigeria USAID Mission for comment. These reports are being used to develop a new communications strategy for Nigeria, to be implemented in FY 16/17. The final versions of the reports will be shared with USAID/Washington AORs for review/approval before publication on FC+ websites. Please see Section III, Nigeria for more information.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

FC+ strengthens provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment, supporting health facilities and their staff to deliver effective clinical care and monitoring of topics ranging from FP counseling to fistula repair outcomes.

Sub-Objective 4.1 Strengthen facility-level capacity to prevent fistula

Good quality obstetric care, including timely recognition and management of prolonged/obstructed labor, is the cornerstone of fistula prevention. FC+ efforts to strengthen fistula prevention at the facility level primarily relate to increasing capacity for FP, labor monitoring, and EmOC. Training and monitoring efforts, as well as provision of FP counseling and services are described below.

To assess the quality of labor monitoring and management of prolonged/obstructed labor, FC+ conducts partograph reviews annually at facilities that receive FC+ support for labor and delivery

care. When possible, reviews are also conducted at facilities where FC+ plans to provide such support during the life of the project, even if the support is not currently being provided. Such support may include training, supervision or other inputs related to EmOC, BEmOC, partograph/labor monitoring, and C-section. Support may also include provision of supplies, equipment and/or expendables, through a formal agreement, for labor and delivery services as well as improving infrastructure and/or systems (i.e. data capture, supervision, monitoring).

A record review tool was developed by FC+ M&E and clinical staff, during FY 14/15, to be completed as either a stand-alone data collection activity or in conjunction with clinical visits/medical monitoring visits at facilities supported for L&D services and treatment. The review focuses on the partograph as a labor monitoring tool, for the purpose of identification of and timely response to obstructed labor specifically. The review looks at a sampling of patient files to determine whether essential elements of the partograph form have been completed correctly and utilized in decision making for the patient. The tool also includes questions related to facility and workforce labor and delivery capacity.

A total of 676 records from FY 14/15 were reviewed at a total of 28 facilities in four countries (Bangladesh, Niger, Nigeria, and Uganda), see Appendix M for detailed scores by site. A total of 658 records from FY 15/16 were reviewed at a total of 29 facilities in four countries (Bangladesh, DRC, Niger, and Uganda), see Appendix N for detailed scored by site. Nigeria completed its FY 14/15 records monitoring mid-way through FY 15/16. Therefore, monitoring of FY 15/16 records will not be completed until early on in FY 16/17. In Nigeria, the monitoring of FY 14/15 records served as a baseline for sites that may receive future labor and delivery service strengthening support in the future.

Record review indicated wide variety in rates and quality of partograph completion between sites, and between countries. In Niger and DRC, all or most patient files contained partographs (100%, 74% respectively), while fewer included partographs in Bangladesh and Uganda (59%, 51% respectively) although there were individual sites in both Bangladesh and Uganda with 100% partograph inclusion. Also in Bangladesh and Uganda, when partographs were not present in a patient file, relevant data was still often recorded, just not using the partograph form. The majority of records reviewed were not referral cases, or not clearly identified as referral cases, which made it difficult to measure the number of records that included a partograph from the referring facility.

The review tool examined four specific parts of the partograph for completion: Contractions monitored half-hourly; fetal heart rate monitored half-hourly; and maternal blood pressure and pulse monitored either at admission or throughout labor. In Bangladesh, contractions were monitored in 56% of records, with the other components recorded in 80-100% of records. This is an improvement over findings in FY 14/15, where only about 40% these components were completed. In Niger, contractions and fetal heart rate were monitored in 50% of records (a decline from 88%), with the other components present in 100% of reviewed records (consistent with FY 14/15 data). In DRC, contractions and fetal heart rate monitoring were found in less

than 50% of records (48% and 35% respectively), while maternal blood pressure and pulse were recorded more frequently (72%). Finally, in Uganda, contractions and fetal heart rate were present in about 70% of the records (an improvement from the 60% found in FY 14/15), while maternal blood pressure and pulse were present in about 40% of records, consistent with findings from the previous year.

Records were also assessed to determine whether the partograph included a crossed action line, and if so, whether action was taken to address the prolonged or obstructed labor. Very few records included partographs with crossed action lines, but in nearly all those cases, action was taken.

Overall, the record review indicated that the partograph implementation at supported sites greatly varies in terms of completeness and correctness. FC+ will continue to utilize these findings in programmatic workplanning for FY 16/17.

During FY 15/16, FC+ supported sites reported a total of 81,485 deliveries in four program countries. Data was not available from Nigeria as work directly related to supporting obstetric care services had not yet begun at supported sites.

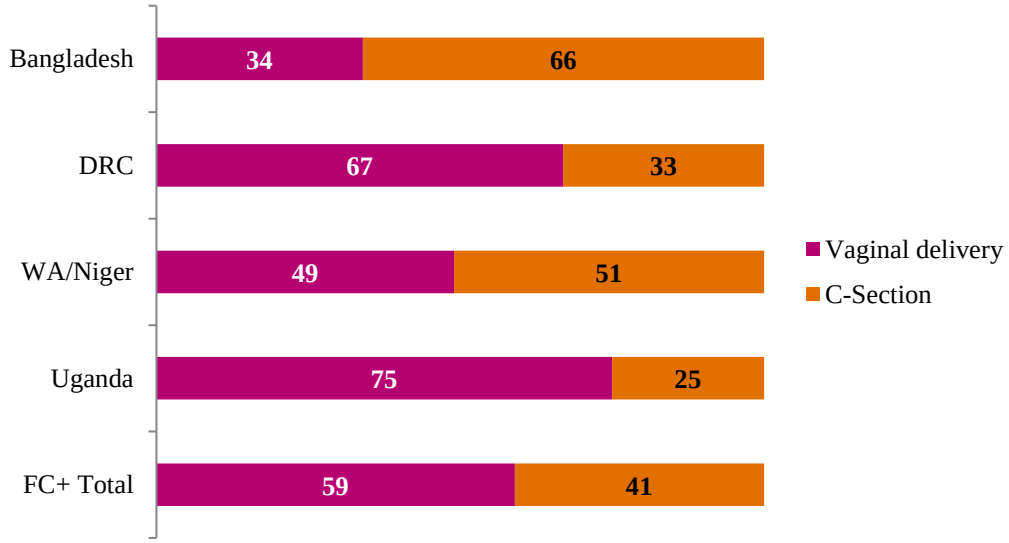
FC+ supported sites tend to be higher-level facilities that are more likely to receive referrals and complications; this contributes to a high proportion of C-section deliveries relative to the national average C-section rates in these countries. The total C-section rate across all FC+ supported sites was 41% (Figure 3). C-section rates at supported sites vary widely at the country level (from 25% in Uganda to 66% in Bangladesh) and at the facility level, due to varied patient profiles and clinical mandates of different facilities.

Across supported sites, 3.4% of all deliveries had prolonged/obstructed labors, with 26% of those prolonged/obstructed labors receiving catheterization for fistula prevention. Reported rates of prolonged/obstructed labor and catheterization also vary widely by site and by country (e.g., Bangladesh 0.3% obstructed/prolonged and 93% receiving catheterization and West Africa Region/Niger 18% obstructed/prolonged and 46% receiving catheterization). Site-level data can be found in Section III, by country.

FC+ and the American College of Obstetrics and Gynecology (ACOG) continue collaboration on ACOG Global Program's C-section/EmOC training in Uganda, known as the Structured Operative Obstetrics (SOO) pilot. This ACOG Global Programs (http://www.acog.org/About-ACOG/ACOG-Departments/Global-Womens-Health) initiative rejuvenates the prior under-funded Canadian Network for International Surgeons (www.CNIS.ca) cesarean skills program in Uganda and is geared toward assuring minimum acceptable levels of cesarean delivery skills among house officers in their final year of obstetrics training. FC+ sent two female obstetricians from FC+ sites as observers in the SOO launch activities in early FY 15/16. FC+ and ACOG Global are working towards a Memorandum of Understanding (MOU) and a PSA to govern collaboration on the second phase of the SOO pilot, to be implemented in FY 16/17. The FC+ role will be to insure appropriate monitoring and evaluation of SOO training activities, including

the use of clinical data for decision making (DDM) approaches during implementation and adequate documentation to support advocacy for SOO scale-up in Uganda.

Figure 3: C-Section Rates, by Country, FY 15/16 (n=81,485 deliveries).



Sub-Objective 4.2 Increase capacity for treatment

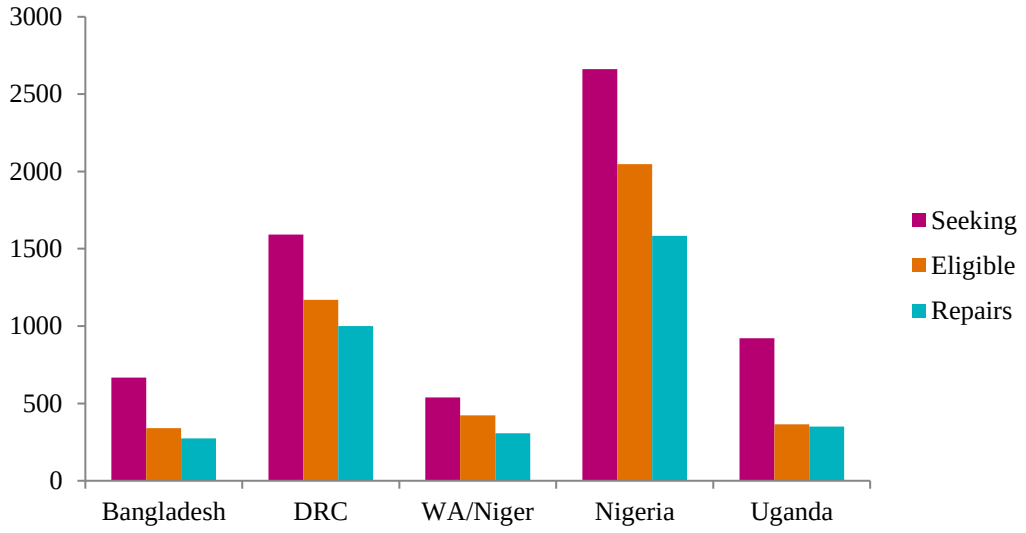
As described under Objective 1, FC+ has commissioned Medical Aid Films (MAF) to create a 20-minute orientation video to complement the formal roll-out of the FC+ Surgical Safety Toolkit during the first half of FY 16/17. The main objective of the film is to support systems strengthening around fistula surgery through improving understanding and utilization of the Toolkit during health worker training. The film will tackle current barriers by demonstrating the simplicity of the Toolkit, showing that the culture of safe surgery is an emerging global community, and demonstrating the positive impact that Toolkit implementation can have on staff time and workload. The film may also serve as an advocacy tool for health policy makers, reflecting the principles of the Global Surgery communities of practices (G4 Alliance, Lancet Global Surgery, WHO Global Surgery Initiative). A PSA has been finalized with MAF and filming is scheduled to begin in October 2016 in Nigeria.

During FY 15/16, a total of 6,380 women with severe incontinence symptoms sought fistula care services at FC+ supported sites. Of these women, 4,798 were diagnosed with fistula (75% of those seeking). Of those diagnosed, 4,343 were medically eligible for surgical repair (91%). FC+ supported the provision of 3,514 surgical fistula repairs in FY 15/16 (81% of those eligible). See Figure 4 for data on women seeking and requiring fistula treatment and the number of surgical repairs supported, by country. Site level information is presented in Section III, by country.

Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through established monitoring and evaluation data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have

multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

Figure 4: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, By Country, FY 15/16.



Including projects receiving bilateral funding, a total of 5,111 surgical repairs were supported by USAID in seven countries (Bangladesh, DRC, Mali, West Africa Region/Niger, Nigeria, Tanzania, and Uganda) during FY 15/16, of which 3,514 (70%) were supported through FC+ (see Figure 5 and Table 10 for detail). The remaining 1,597 surgical repairs were supported by USAID bilateral projects. Site level repair data is presented in Section III, by country.

Figure 5: USAID-Supported Surgical Fistula Repairs, by Quarter, FY 15/16 (n=5,111)

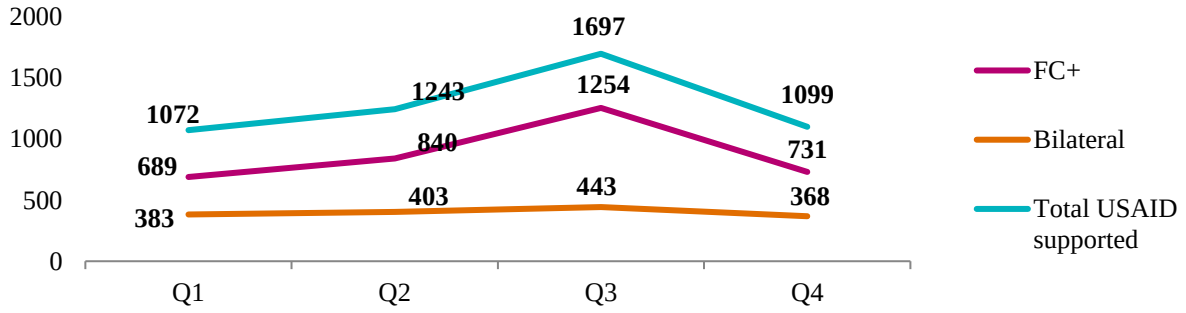


Table 10: Number of USAID-Supported Surgical Fistula Repairs, by Country, FY 15/16.

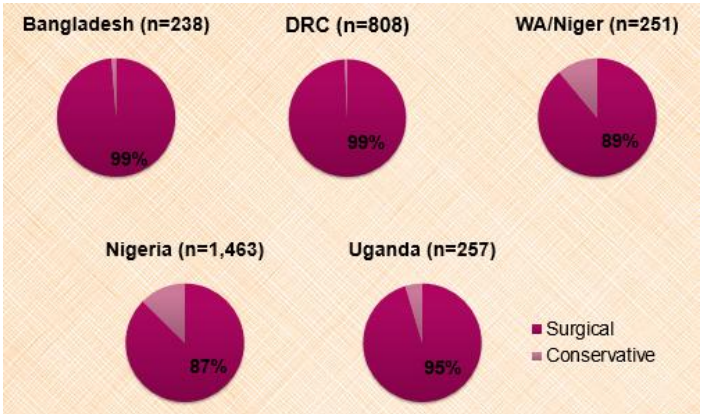
Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sept 2016	Total FY 15/16
Bangladesh	96	77	62	38	**273**
DRC	134	163	505	198	**1000**
WAR/Niger	47	110	66	85	**308**
Nigeria	363	428	487	305	**1,583**
Uganda	49	62	134	105	**350**
Total FC+	689	840	1,254	731	**3,514**
DRC: ProSani (bilateral)	60	60	60	60	**240**
Mali: IntraHealth (bilateral)	63	118	63	n/a	**244**
Tanzania: Vodafone/CCBRT (bilateral)	260	225	288	275	**1,048**
Guinea: Jhpiego HSD project	NS	NS	32	33	**65**
Total USAID bilateral	383	403	443	368	**1,597**
Total All USAID-supported	**1,072**	**1,243**	**1,697**	**1,099**	**5,111**

Year 3 Clinical Highlight: Expanding Non-Surgical Treatment

FC+ has supported the adoption, expansion, and improvement of non-surgical fistula treatment through catheterization. This has the potential to dramatically expand access to fistula repair for clinically eligible women. Non-surgical treatment also gives women the option to forego a lengthy hospital stay for a surgical repair, often a barrier to care-seeking, and receive a less invasive intervention if deemed medically eligible.

FC+ is building the capacity of clinicians and sites to identify appropriate fistula clients and provide conservative treatment. In addition to the surgical repairs described above, FC+ supported conservative treatment of fistula using catheterization for a total of 323 women during FY 15/16 (see Figure 6). In all countries but Niger, the majority of these fistulas (82-100%) were successfully closed. Most catheter treatments were performed in Nigeria (n=261, 81%), where guidelines for catheter treatment of fistula, adapted from the proceedings of a 2013 Fistula Care project consultation, were recently approved by the Federal Ministry of Health (FMOH) (see Section III: Nigeria). FC+ will showcase experiences with non-catheter treatment at the ISOFS Conference in Abuja, Nigeria in October 21016. The USAID bilateral project ProSani also supported conservative treatment for ten women during the first quarter.

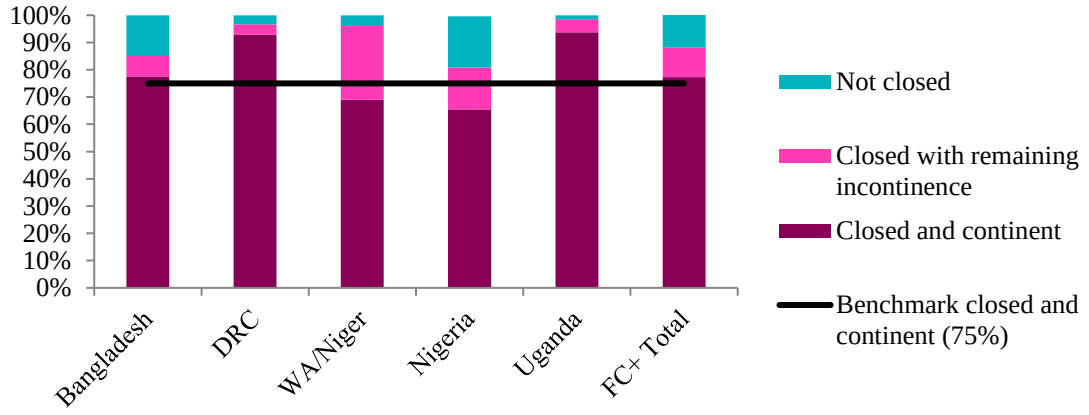
Figure 6: Conservative vs. Surgical Fistula Management, By Country, FY 15/16



Along with catheter treatment (see highlight box above), FC+ is also seeking to expand another aspect of non-surgical fistula and POP treatment - physical therapy. In FY 15/16, FC+ employed a physical therapy questionnaire for partner sites in DRC and Nigeria, as part of efforts described in Objective 1, to better understand existing site capacities and what efforts are needed to address gaps. Results from the survey will be presented at the October 2016 ISOFS conference.

At the start of FY 15/16, FC+ revised its clinical data collection indicators to include greater specificity regarding the etiology of fistula being diagnosed at supported sites. FC+ was able to collect this etiology data for 56% (n=2,702) of all diagnosed cases. Data reported during FY 15/16 indicate that, of cases with available data, the etiology of the diagnosed fistula was: obstructed/prolonged labor 72% (n=1,947); iatrogenic 20% (n=533); traumatic 6% (n=165); and other causes (primarily cancer or congenital) 2% (n=57). Provider error during medical procedures has emerged as an important contributor to the fistula burden, causing a higher proportion of cases than traumatic fistula in most settings. FC+ collected data from supported sites on the number of cases deemed by the operating surgeon to be iatrogenic fistula. Currently, 30 supported sites report this data; as noted above, in FY 15/16 these sites reported that 20% of all diagnosed fistula cases where etiology data were available were identified as iatrogenic in nature. However, a higher percent of cases was identified as iatrogenic in Bangladesh (35.8%) and DRC (25%) (see Section III, by country). Increasing discussion with country and site teams is required to ensure all sites are identifying probable iatrogenic fistula cases with consistent criteria. FC+ has considered recommending the algorithm proposed in an FC+ co-authored paper on iatrogenic fistula;[4] however, there continues to be debate about the anatomical signs and clinical history that are indicative of iatrogenic fistula. Across FC+ countries, clinical teams will work with in-country partners to develop consensus definitions for classifying fistula by etiology in FY 16/17. FC+ has authored a technical brief and held a webinar during the fiscal year to encourage awareness and action on this issue.

Figure 7. Outcome Rates for Fistula Surgical Repairs, by Country, FY 15/16.



4 Raassen TJ, Ngongo CJ, Mahendeka MM. Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries. Int Urogynecol J. 2014 Dec;25(12):1699-706. http://www.ncbi.nlm.nih.gov/pubmed/25062654

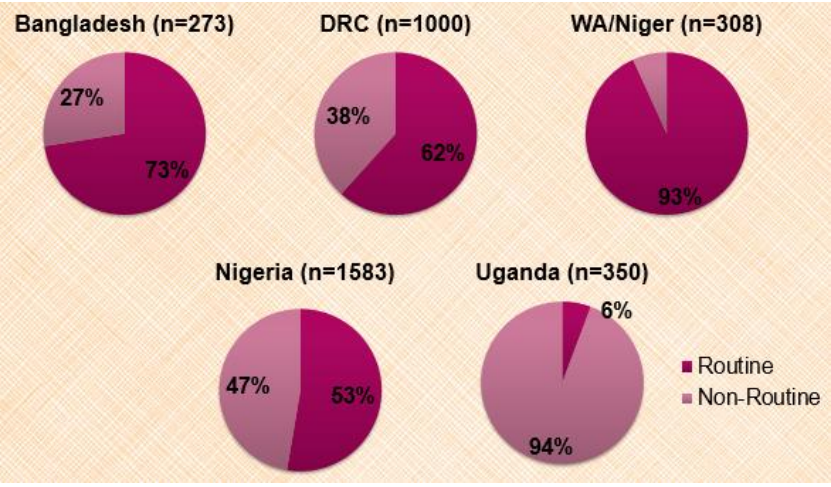
During FY 15/16, 88% of all discharged FC+ repair cases were closed at the time of discharge. 77% of all cases are closed and continent (i.e., dry in the case of fistula resulting in leakage of urine) at discharge, 11% were closed with remaining incontinence, and 12% were not closed. Closed and continent rates are a potentially non-informative indicator for quality of care, in that a patient can have suboptimal outcome even when the quality of fistula care meets or exceeds an acceptable standard. This is exacerbated by variations in case mix, i.e., if some facilities are caring for many more patients with complex fistulas and complicating incontinence co-morbidities. However, in tandem with other clinical indicators (e.g., complications), this indicator may be useful in identifying settings where audit and analysis of the case mix, skills and materials that underpin evaluation and management of post-fistula incontinence, overall quality of care, and other issues may be warranted. Historically, the project has set a benchmark of 75% for the proportion of discharged cases deemed closed and continent. When rates fall below benchmarks, FC+ investigates the causes to determine whether follow-up action is necessary.

As presented in Figure 6, national closed and continent rates in Niger and Nigeria fell below this benchmark. Explanations for low closed and continent rates during this reporting period and,

Year 3 Clinical Highlight: Increasing Routine Fistula Treatment Services

In FY 15/16, FC+ continued to encourage a greater emphasis on routine surgical fistula repair services, as opposed to models relying on pooled efforts, camps, concentrated repair efforts, etc. In addition to promoting sustainability, particularly when integrated with other services such as POP evaluation and management, routine service models encourage broader quality improvements and surgical safety in fistula care. This fiscal year was the first reporting period in which treatment sites supported by FC+ in Uganda provided routine surgical fistula repairs. In FY 15/16, the majority of surgical fistula repairs in Nigeria were also provided through routine services, vs. pooled efforts; this is a notable transition given past policy emphasis on pooled efforts. The approaches that have encouraged these shifts are discussed further in Section III: Nigeria and Uganda.

Figure 8: Routine vs. Non-Routine Fistula Repair, By Country, FY 15/16



when relevant, the steps being undertaken to address them are discussed in Section III, by country.

Of the 3,314 discharged cases during the fiscal year, data on level of fistula complexity were available for 1,453 cases. Of these, 65% were simple fistula and 35% were not simple. Simple fistula made up approximately 50-60% of the reported cases in all countries except Uganda where simple fistula represented a higher proportion of discharged cases (96%).

Reported complication rates for surgically repaired fistula cases at supported sites were generally low (2.7% project-wide), with countries reporting rates ranging from 0% in Niger to 4% in Bangladesh. Project benchmarks define a complication rate of <20% to be acceptable. Country-specific data on complication rates can be found in Section III.

To strengthen surgeon capacity for fistula repair, during FY 15/16, FC+ trained a total of 16 surgeons in three countries (Bangladesh, DRC, and Nigeria) in fistula surgical repair, based on the FIGO training curriculum. 10 surgeons participated in their first training in fistula surgical repair and six took part in continuing training (see Table 11). More detailed training information can be found in Section III, by country.

Table 11: Training in Surgical Fistula Repair, Participants by Quarter, FY 15/16

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
First Training in Surgical Fistula Repair	0	7	6	1	**10**[5]
Continuing Training in Surgical Fistula Repair	1	2	1	3	**6**[6]
Training to be a Trainer	0	0	0	0	**0**
Total	**1**	**9**	**7**	**4**	**16**[7]

A total of 1,414 health system personnel in six countries (Bangladesh, DRC, Niger, Nigeria, Togo, and Uganda) participated in training in non-surgical topics during FY 15/16, including data management, EmONC, FP provision, fistula and FP counseling, pelvic floor rehabilitation, non-surgical POP treatment, pre- and post-operative care and infection prevention (see Table 12). These trainings contribute to fistula and POP prevention, identification, referral, treatment, and post-repair services as well as clinical data management.

Table 12: Training for Health System Personnel (excluding fistula/POP surgery), Participants by Quarter, FY 15/16.

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
ANC	0	0	0	0	**0**
Community, outreach and advocacy	0	15	30	27	**72**
Data management	0	40	20	63	**123**
EmONC	2	0	0	32	**34**

[5] Several surgeons received trainings over multiple quarters, therefore the sum of each quarter is greater than the total actual number of surgeons trained.

[6] One surgeon received trainings over multiple quarters, therefore the sum of each quarter is greater than the total actual number of surgeons trained.

[7] Several surgeons received trainings over multiple quarters, therefore the sum of each quarter is greater than the total actual number of surgeons trained.

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
EmONC and labor monitoring	0	29	58	186	**273**
FP counseling	170	0	0	0	**170**
FP methods	0	50	0	22	**72**
FP and fistula counseling	0	0	0	12	**12**
Fistula counseling	9	0	10	0	**19**
Gender	0	0	0	0	**0**
Infection Prevention	54	164	18	93	**329**
Labor monitoring	0	0	0	0	**0**
Non-surgical POP treatment	0	0	30	0	**30**
Pre- and Post-Operative Care	6	9	58	84	**157**
Quality Assurance	0	0	41	35	**76**
Other	0	0	47	0	**47**
Total	**241**	**307**	**312**	**554**	**1414**

In March-April 2016, FC+ sponsored surgeons from DRC, Mozambique, Niger, Nigeria, and Uganda to attend the UroDak workshop held in Dakar, Senegal. UroDak is a multidisciplinary, advanced urologic and gynecologic workshop held in Dakar, Senegal every two years. UroDak is organized by IFRU-SF (Institution de formation et de Recherche en Urology-Santé Familiale), chaired by Professor Serigne Magueye Gueye, in Senegal. The goal of the workshop is to provide opportunities for urologists, obstetricians-gynecologists, surgeons, nurses, midwifes and other health professionals to share surgical experiences and set partnerships in the field of urology and reproductive health research, training and care. This year's workshop provided specific training for complex fistula and complications of fistula (e.g., vaginal fibrosis).

In July, 2016, FC+ sponsored six senior surgeons and project consultant/UroDak founder Professor SM Gueye to attend the 14th annual UroMap conference, a high-level reconstructive pelvic floor workshop for advanced uro-gyneco-colorectal reconstructive surgery, sponsored by renowned fistula surgeon, Dr. Igor Vaz, in Maputo Mozambique. The immediate utility to the senior surgeons attending these workshops is the acquisition of advanced skills with which they may address complex caseload contributing to fistula backlog. FC+ has also retained Dr. Vaz as a surgical trainer consultant to the project to work with surgeons in need of complex case training in their home facilities.

In FY 15/16, FC+ developed a draft Surgical Safety Toolkit, a set of clinical trackers and quality assurance checklists. The Toolkit is a compendium of resources for surgeons and allied clinicians to improve fistula repair services and support the provision of surgical care at a minimum acceptable standard, as outlined by global actors such as the World Health Organization and the Global Alliance for Surgical, Obstetric, Trauma, and Anaesthesia Care (The G4 Alliance) The Toolkit addresses gaps in clinical record keeping and monitoring that have been identified by FC+, and provides resources that build a platform for ongoing quality assurance in fistula services past the duration of the project. The Toolkit is a novel, integrated package that includes a client tracker of clinical outcomes for surgical and non-surgical care for fistula, prolapse and incontinence; a surgical skills tracker designed to document return on investment of funded clinician training, for fistula, prolapse, and incontinence; a sentinel event tracker designed to

identify time trends of near-miss morbidity events that will augment the existing system of mortality review and help target quality improvement support to facilities. The Toolkit also guides and supports staff teamwork behaviors with seven surgical safety checklists covering topics ranging from candidacy for surgery to daily post-operative care and discharge follow-up planning. The checklists are integrated into the client tracker and were designed to meet specific requests from supported sites that shared internally identified gaps within facility care systems.

The Toolkit is being refined with input from surgeons in all countries where FC+ works. Systems and staff roles related to in-depth clinical monitoring using the Toolkit are in discussion, including at the clinical data for decision making (CDDM) mid-project check-in in Addis Ababa immediately in June 2016. The Toolkit will be rolled out at an FC+ clinical meeting following the 2016 ISOFS conference.

Sub-Objective 4.3 Integrate family planning (FP) services to respond to client needs

FC+ supports efforts to strengthen integration of FP in fistula treatment services and broader maternal health care at supported sites. During FY 15/16, the FC+ global team provided technical assistance on FP including sharing medical eligibility criteria updates and guidelines, leading an FP integration workshop in Nigeria, and assisting with a rapid evaluation of FP services at partner sites in DRC that included establishing an action plan for implementation of identified needs and advocacy with the local mission to increase FP commodities. FC+ also has a team in place to ensure compliance across sites with all USAID requirements.

During FY 15/16, a total of 366,038 counseling sessions were provided at supported sites, and FP services resulted in a total of 195,986 Couple Years of Protection (CYP). 198,614 of these counseling sessions and 89,341 of this CYP was reported from the 500 former USAID Targeted States High Impact Project (TSHIP) facilities in Nigeria where the FC+ role is primarily to monitor family planning services. The method mix contributing to this total CYP (FC+ sites/Former TSHIP sites) includes implants (44/50%), tubal ligation (16/0%), injectables (14/23%), IUCD (13/3%) and oral pills (4/7%). Country specific counseling information is provided in Figure 7 and CYP information in Figure 8, with country- and site-specific information provided in Section III.

Figure 9. Family Planning Counseling Sessions, by Country, FY 15/16 (n=366,038)

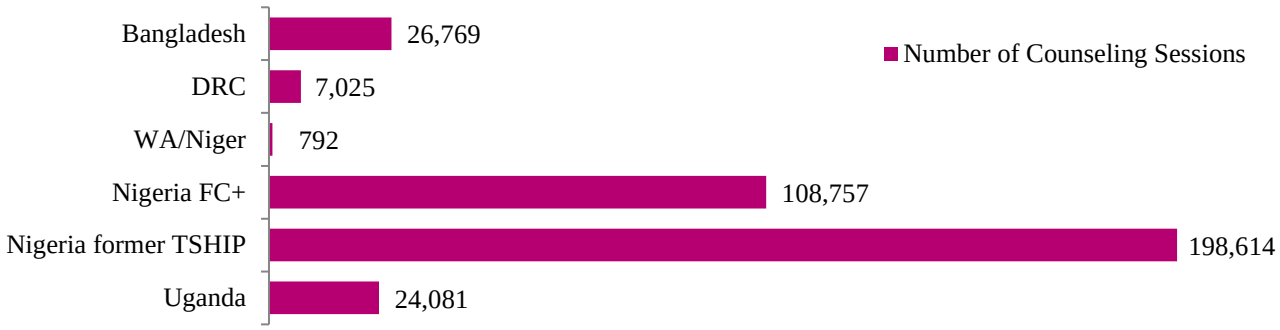
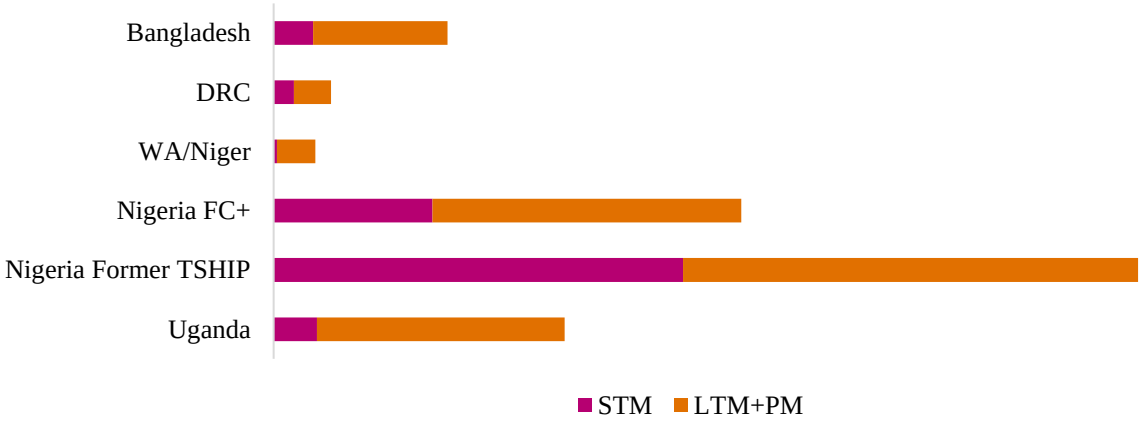


Figure 10. Family Planning CYP, Short-Term vs. Long-Term/Permanent Methods, by Country, FY 15/16 (n=195,986)



Sub-Objective 4.4 Support and establish treatment/care programs for WDI and POP

During FY 15/16, FC+ has worked to develop program plans for the establishment and support of treatment for WDI and women suffering from POP.

Building on the recommendations of the POP integration consultative meeting in the fall of 2015 in NYC, and the work done in the spring of 2016 to produce a causal pathway with proposed indicators for the strategy, exploratory trips were carried out by consultant surgeons: Judith Goh to Jinja, Uganda in May-June 2016 and René Genadry to the Centre National de Reference des Fistules Obstetricales (CNRFO) and the Urology Department at Lamorde National Hospital in Niger in June 2016. The findings of both of these trips helped to refine the piloting strategy, with the following sites identified for pilot efforts in order to represent three distinct models for study. Working at Kagando Hospital in Uganda (a private NGO site) will allow transfer of POP skills to senior Ugandan surgeons who are training junior surgeons at the Jinja Regional Hospital. In Nigeria, the project has the opportunity to capitalize on a newly launched female pelvic medicine fellowship at University of Ibadan under the directorship of Professor Olodosu Ojengbede.

Professor Ojengbede has agreed to permit FC+ supported participation in non-fellowship level skills training for senior and junior surgeons from Abakaliki Federal Medical Center. In DRC, capacity is being built in a south-to-south exchange between Panzi and St. Joseph's Hospitals. Due to severe deficits in infrastructure, supplies and surgical and anesthetic safety mechanisms, POP integration activity in Niger will be restricted to advocacy for surgery and anesthesia ecosystem capacity building towards a future that permits adding elective POP surgery to fistula service centers, without diverting scarce resources from fistula patients or overtaxing fistula sites' ability to engage in safe surgery practices.

In August Renée Fiorentino, a midwife and formerly a Senior MER Associate on the prior FC project, joined as a consultant to steward, support implementation of and monitor work plans for the POP integration strategy. Draft FY 16/17 work plans for the three countries involved in POP integration (DRC, Nigeria, and Uganda) have been developed. These plans and their measurement strategies will be discussed and refined at the FC+ clinical meeting to be held in October 2016 in Abuja, following the ISOFS conference.

The FY 14/15 survey of FC+ supported sites identified a crosscutting lack of adequate pessary supply for non-surgical POP treatment. Recognizing the importance of central pessary procurement for the duration of the POP integration pilot, a vendor offering a unit price at 60% of the cost of the majority of the market has been identified and will provide free sizing kits. Review of existing training materials for pessary fitting and counseling is underway, preliminary analysis yielding the conclusion that there is no need for a project-specific curriculum.

As of September 30, 2016, 10 FC+ supported sites (four in DRC, two in West Africa/Niger, and four in Uganda) provide routine data on conservative and surgical POP treatment. During the fiscal year, these sites reported that 1,739 women sought treatment for possible POP symptoms with 1,137 women diagnosed with and requiring treatment for POP (65% of those seeking). A total of 1,033 women received POP treatment during this period (91% of those requiring). Supported sites provided 1,644 conservative POP treatments and 1,037 surgical POP treatments (some women may receive both conservative and surgical treatment). Conservative POP treatments at reporting sites presently overwhelmingly consist of counseling and physical therapy with only 11 pessaries reported. This evidence strengthens the rationale for FC+ efforts to increase the availability of pessaries, as described above. POP treatment data is presented by country in Table 13.

Table 13. Number Seeking, Requiring, and Receiving POP Treatment, by Country, FY 15/16.

Country	#Seeking	#Eligible	% of Seeking	#Receiving	% of Eligible
DRC	1,502	921	61%	853	93%
WA/Niger	111	95	86%	61	64%
Uganda	126	121	96%	119	98%
Total	**1,739**	**1,137**	**65%**	**1,033**	**91%**

1.3% of women receiving surgical POP treatment experienced complications. Given the nature of surgical POP repair, it is to be expected that all treated women would be considered "cured" at the time of discharge. The project is not currently able to gather longer term follow up data to monitor repair breakdown after discharge.

Objective 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

FC+ strengthens the evidence base for approaches to improve fistula care and promotes M&E scale-up by ensuring that FC+ activities are appropriately documented and disseminated and by learning from and contributing to the knowledge of the fistula community as well as the broader maternal health sector.

Throughout the fiscal year, FC+ ensured compliance with USAID's and EngenderHealth's policies and procedures for research and evaluation dissemination by including all studies and reports on internal and external databases.

Sub-Objective 5.1 Increase standardization in terminology, classification, and indicators

At the end of FY 15/16, FC+ developed data collection tools and a sampling plan for a qualitative study that will document the process by which fistula indicators are being adopted and integrated into five countries' HMIS. The countries include Bangladesh, Guinea, Niger, Nigeria, and Uganda. Data collection will occur in the second quarter of FY 16/17.

In F14/15, FC+ collaborated with WHO colleagues on a secondary analysis of data collected in two FC Project studies: the observational study on fistula outcomes and the randomized controlled trial (RCT) on duration of catheterization. Preliminary results provided an emerging inductive five-category classification system for fistula cases. However, these categories included both sociodemographic and clinical characteristics, making it difficult to deem the classification system a clinical tool that would be viewed as valid by fistula surgeons beyond the several competing models already in use. Following discussion at FC+ and with USAID, we have decided not to continue with this analysis, as it is not likely to provide a result that is useful beyond the various classification systems and counseling/discharge planning approaches that are currently available.

Sub-Objective 5.2 Strengthen monitoring and evaluation/research (ME&R) systems and use of data

In June 2016, seven FC+ staff members from four countries (Bangladesh, Niger, Nigeria and Uganda), as well as the FC+ Global team, participated in a meeting organized by EngenderHealth on Clinical Data for Decision-Making (CDDM). The week-long meeting in Addis Ababa was intended to improve the way EngenderHealth programs capture and use clinical data which relates to service delivery and the implementation of quality improvement interventions, including training, monitoring, supervision and coaching. The meeting participants

represented clinical and monitoring and evaluation staff from EngenderHealth's field and headquarter offices. FC+ staff presented on data quality assessment work as well as development and use of the project's DHIS2 database. A complete agenda and participant list for this meeting can be found in Appendix G.

FC+ organized a one-day follow-on meeting to the EH CDDM meeting in June 2016. FC+ staff were able to continue the discussion on how best to harmonize clinical and routine monitoring and evaluation data and to ensure that the project is gathering information efficiently and effectively, and utilizing it to improve both programmatic performance as well as service delivery at supported facilities. The meeting provided an opportunity for country-specific updates on data collection and utilization as well as review and discussion of the proposed new clinical and client level trackers under development by the project see Objective 4) The full agenda for this meeting can be found in Appendix H.

To operationalize the FC+ PMP, a key activity through the life of the project has been developing and updating FC+ M&E and data management systems. FC+ has built a DHIS2 platform to function as the global M&E database for the current project.

The FC+ Senior M&E Associate met with USAID/Washington during the second quarter of FY 15/16 to provide an interactive training on accessing and customizing a DHIS2 dashboard developed specifically for USAID/Washington. Based on that training, the dashboard will continue to be customized to best meet the data needs of USAID/Washington staff

The Project Director identified and implemented several changes to the indicators collected quarterly from supported sites (see Section I, PMP Revisions). These changes include greater specificity on the etiology of diagnosed fistula, monitoring client backlog at supported sites, ensuring consistent terminology regarding surgical repair outcomes, and revising POP service indicators to best monitor that work as the project begins its implementation phase. Once changes were finalized, the project DHIS2 system was updated accordingly and all relevant project M&E and program staff received an orientation to the changes.

FC+ responded to requests from Metrics for Measurement, a US-based NGO tasked with supporting the DHIS2 community by documenting best practices, advancing knowledge resources, and working with our partners to expand capacity building initiatives. We have shared our experiences and lessons learned with development of our platform, providing an example of "do it yourself" development on a small scale.

FC+ conducts internal DDM exercises after the close of each quarter to discuss program data and identify issues in need of follow-up. Country programs implement similar processes. In Nigeria and Uganda, the annual Providers' Network Meeting, convened by FC+ and the MOH, provides an opportunity to reflect on both national and site level data trends.

The project works with supported treatment sites to encourage ongoing review of site-specific data to identify and act upon areas of clinical and programmatic concern and opportunity to improve fistula services. While it is ideal for sites to review data on a monthly or quarterly basis,

depending on service volume, experience from the original FC project indicates that this is very difficult for sites to achieve, given shortages in human and other resources. However, improvements in data review are occurring at supported sites: 68% of FC+ supported treatment sites met at least twice during the fiscal year to review their data, compared to 55% in FY 14/15; 97% (compared to 66% in FY 14/15) met at least once (See Appendix Q for country and site details). In addition to facilitating such reviews when requested, FC+ has also trained 123 health personnel throughout the fiscal year in data management and DDM.

Sub-Objective 5.3 Use research findings to improve practice

As described in Section I of this report, FC+/EH continued collaboration with the Maternal and Child Survival Program (MCSP), which included convening a meeting to discuss and review a draft user guide for short labor and delivery quality of care indices developed by the FC+ Deputy Director, with MCHIP support; and the dissemination of information about these indices through an MCSP-led panel at the Global Maternal and Newborn Health (GMNH) Conference in Mexico City in October 2015. Once completed, plans are underway to pilot the tools at FC+ prevention sites.

FC+ has also, as described in Objective 1, made efforts to share program data and experience about the growing burden of iatrogenic fistula. In August 2016, as part of the recently launched Fistula Community of Practice (FCoP), FC+ organized a webinar entitled "A Call to End Iatrogenic Fistula", featuring the Project Director and Deputy Director, and moderated by the Global Projects Director. Given the preventability and severity of fistula, data on iatrogenic fistula indicate the urgency of improving surgical training, supervision, and facility capacity, particularly amid increasing rates of C-section section and gynecologic surgery in low-income countries. 122 participants registered for the webinar, which allowed for questions and answers following the presentations. The webinar recording is available on the FC+ website (https://fistulacare.org/what-is-fistula/iatrogenic-fistula/).

During the first half of FY 15/16, the Deputy Director worked with the Population Council to review and build on findings from the formative research carried out in Uganda and Nigeria in FY 14/15. Based on the research findings, a plan for intervention research has been refined including intervention design, site selection, and identification of mHealth partner for the fistula screening hotline component of the intervention, as described in Objective 3.

In FY 15/16, FC+ also continued to share results from the FC project RCT on the non-inferiority of shortened duration of catheterization after surgical repair and has been in contact with WHO regarding their plans to release a recommendation on catheter duration as a follow up to the trial results. FC+ collaboration with WHO on the RCT has resulted in an invitation to partner on a systematic review of the literature on catheterization, which will lead to a consultative meeting and issuance of a formal guideline in support of short duration catheterization. The consultative meeting is expected to take place in FY 16/17, with WHO and FC+ sharing costs.

Conference presentations and publications continue to be an important strategy for FC+ to share the findings of its research and evaluation activities, and to foster evidence-based change in research and program practices. Throughout the fiscal year, FC+ convened and presented at multiple meetings and conferences as part of efforts to disseminate findings from research and program evaluations, see Table 4 for details.

FC+ had a strong presence at the 2015 FIGO Conference held in Vancouver, British Columbia in October 2015, with ten staff members attending from six countries. FC+ staff and partners presented eight oral presentations and two posters, representing activities in four country programs and at a global scale. A full list of participants and presentations can be found in Appendix D. FC+ also convened a panel on iatrogenic fistula at the GMNH Conference and presented on POP and fistula services integration as well as iatrogenic fistula at the 2016 Global Health Partnerships meeting at the Royal College of Surgeons in Ireland (April 2016).

FC+ and EngenderHealth developed three events for the 2016 Women Deliver conference, held in Copenhagen in May 2016, detailed under Objective 1. These included a panel discussion on the role of health systems in maternal and newborn morbidity, an event exploring the intersection between access to safe surgical care and women's health, maternal mortality and gender equality, and a reception to honor accomplishments related to sexual and reproductive health and rights work. Additional information on these events can be found in Appendix C.

In addition, FC+ developed and submitted 36 abstracts and several plenary/workshop concepts from FC+ staff/partners that were accepted for poster or oral presentation at the 2016 ISOFS Conference in Abuja, Nigeria (see Appendix T). Additionally, FC+ was asked to present on global pelvic floor health in plenary and supported consultants to present on physical therapy for pelvic floor dysfunctions at another plenary. As noted in Objective 1, FC+ is also developing agenda contributions for the IOFWG meeting to precede the ISOFS Conference.

FC+ also submitted abstracts to and was accepted for presentations at two additional conferences to occur in FY 16/17:

- 2016 Health Systems Research Symposium - two abstracts submitted and accepted: 1) Expanding health system capacity to provide surgical care in low-resource settings: integrating pelvic organ prolapse and genital fistula repair (accepted as poster); 2) Addressing barriers to fistula care services by applying the findings of formative research in Nigeria and Uganda (accepted as presentation at satellite event)
- ICM 2017 Congress - three abstracts submitted and accepted: 1) Feasibility of task sharing in primary screening of obstetric fistula clients by midwives – lessons learnt from fistula treatment sites in Uganda (accepted as presentation); 2) use of partograph in tertiary hospitals in Bangladesh: opportunities for making a difference through midwives (accepted as poster); and 3) urinary catheterization after prolonged and obstructed labor: current practices and potential leadership by midwives (accepted as presentation).

FC+ has also sought to contribute to the evidence informing fistula and related programs through the continued publication of reports, briefs, and journal articles. During FY 15/16, four articles were accepted or published in peer-reviewed journals (see Table 14). FC+ ensures that all articles supported with project resources and included in approved workplans are published open-access, in line with USAID policy on research.

As described under Objective 3, research reports on the formative research on assessing barriers to fistula care and treatment in Nigeria and Uganda, carried out by project partner the Population Council, have been finalized. To help disseminate these findings, the Population Council and FC+ jointly prepared two briefs with the Population Council which summarize this formative research.

- Barriers to Fistula Repair in Nigeria: A Formative Study (https://fistulacare.org/wp-fcp/wp-content/uploads/2015/10/Nigeria_Fistula_Barriers-Brief-10-3-16.pdf) Published September 2016.
- Barriers to Fistula Repair in Uganda: A Formative Study (https://fistulacare.org/wp-fcp/wp-content/uploads/2015/10/Uganda_Fistula_Barriers-Brief-8-25-16.pdf) Published August 2016.

Appendix O provides a complete list of FC/FC+ peer-reviewed journal publications and Appendix P provides metrics for readership of articles published by FC/FC+. While metrics are only available for some FC/FC+ articles, these have been viewed more than 25,000 times.

In addition to the articles listed in Table 14, FC+ has published two technical briefs during FY 15/16, available from the FC+ website:

- Iatrogenic Fistula: An Urgent Quality of Care Challenge (https://fistulacare.org/wp-fcp/wp-content/uploads/2015/10/Iatrogenic-fistula-technical-brief_2016-1.pdf) Published August 2016.
- Is It Feasible to Implement a Cesarean Indication Classification System? Findings from Five Countries. (https://fistulacare.org/wp-fcp/wp-content/uploads/2015/10/EH-Csection-brief_Sept-2016.pdf) Published September 2016.

Along with sharing project findings on this topic, the iatrogenic fistula brief outlines a platform for action by the global fistula, maternal health, and global surgery communities to document, address, and prevent iatrogenic fistula.

The FC+ Deputy Director also published a program tool entitled, “The Labor and Delivery Quality of Care Short Observational Index: A User Guide” through the Maternal Child Survival Program (MCSP). This tool is an MCSP product and was reviewed as per their contractual guidance regarding publications. It is available through multiple websites including EngenderHealth, MCHIP and MCSP, as well as USAID’s Development Experience Clearinghouse: (http://pdf.usaid.gov/pdf_docs/PA00MCSH.pdf).

The project's online presence has helped foster relationships with peer organizations, including named partners such as Maternal Health Task Force (MHTF). FC+ is increasingly engaged by partner organizations to participate in Twitter chats and other forms of online discourse focused on maternal health and morbidity. Throughout the fiscal year, the project was contacted by MHTF, DHS, and other organizations to collaborate on articles or blog posts. FC+ has continued to disseminate thought pieces and research findings online through these various platforms.

During FY 15/16, FC+ staff contributed to five posts on partner websites:

- October 2015: Lauri Romanzi, "Let's create disruptive innovation for maternal newborn health at GMNHC 2015"
- October 2015: Vandana Tripathi, "Integration and equity in fistula care: Goals for GMNHC 2015"
- October 2015: Sandeep Bathala (Wilson Center), "Iatrogenic Fistula on the Rise as More Women Gain Access to Surgery." This New Security Beat blog was cross-posted to FC+.
- May 2016: Lindsay Mallick (DHS), "Building Awareness of the Link between Fistula and Gender Based Violence." This DHS blog, written in collaboration with Vandana Tripathi, was cross-posted on MHTF and FC+ blogs.
- August 2016: Kayla McGowan (MHTF), "MHTF Blog: A Call to Action to Address Iatrogenic Fistula." This MHTF blog discussed key points from the FC+ webinar on iatrogenic fistula, and was cross-posted on the FC+ blog.

Additionally, the FC+ Project Director collaborated with G4 Alliance and Gradian Health Systems on a Medium blog post in honor of International Women's Day.

- March 2016: Lauri Romanzi, "On International Women's Day, Let's Help Women Living with Fistula get the Care They Need"

EngenderHealth President Ulla Miller and Dennis Mukwege of Panzi Hospital in DRC published an article in the Huffington Post entitled "Intersection of Human Rights and Healthcare" in May 2016 (http://www.huffingtonpost.com/dr-denis-mukwege/intersection-of-human-rights_b_10106264.html).

Table 14: Peer-Reviewed Articles Published, FY 15/16

Authors	Title	Journal
Delamou, A et al	Pregnancy and childbirth after repair of obstetric fistula in sub-Saharan Africa: Scoping Review	*Tropical Medicine and International Health*. 2016 Nov; 21(11): 1348-1365. http://onlinelibrary.wiley.com/doi/10.1111/tmi.12771/abstract;jsessionid=17E26CAAB1427E8B96E6E075416BDB63.f04t04
Vandana Tripathi	A literature review of quantitative indicators to measure the quality of labor and delivery care[8]	*International Journal of Gynecology & Obstetrics*, published February 2016. http://www.mchip.net/sites/default/files

[8] This article was authored by the Deputy Director and describes work conducted through support from the USAID Maternal and Child Health Integrated Program (MCHIP)

Authors	Title	Journal
		/Lit%20review%20quantitative%20indicators%20quality%20of%20labor%20and%20delivery%20care.pdf
Delamou, A et al	Prevalence and correlates of intimate partner violence among family planning clients in Conakry, Guinea	*BMC Research Notes,* Published online 23 December 2015. http://bmcresnotes.biomedcentral.com/articles/10.1186/s13104-015-1811-7
Delamou A, et al	Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea	*Tropical Medicine and International Health*. 2015 Nov;20(11):1454-1461. http://www.ncbi.nlm.nih.gov/pubmed/26250875

Sub-Objective 5.4 Contribute to the evidence for improved programming and care

In the first half of FY 15/16, FC+ conducted several activities to advance the priorities in the project research agenda developed through consultative meetings in 2014. A number of these have been described above, including: inventory and analysis of survey- and interview-based tools used to identify fistula cases, inputs to the BMMMS and clinical validation sub-study, and formative research on treatment barriers in Nigeria and Uganda.

As discussed above, the FC+ Global and Nigeria teams completed implementation of a communications assessment study in Nigeria, with draft study reports presenting the qualitative and quantitative findings completed in the fourth quarter. FC+ hopes to finalize and disseminate the reports in early FY 16/17.

Since the previous DHS comparative analysis on questions related to incontinence was published in 2008, numerous surveys have used the DHS fistula module. In FY 14/15, the Deputy Director requested the DHS Program to conduct an updated secondary analysis of the data from all surveys using the fistula module; the resulting report is available on the DHS program website (http://dhsprogram.com/publications/publication-OD67-Other-Documents.cfm). During the first half of FY 15/16, the FC+ Deputy Director and DHS Program analyst Lindsay Mallick co-authored a manuscript based on this secondary analysis. The manuscript describes increased risk for sexual/physical violence among women with fistula symptoms and evidence suggesting that this violence is a consequence of fistula, rather than its cause. The manuscript was received USAID approval in March 2016 and is currently under revision for journal publication.

As described under Objective 2, the Deputy Director worked with project partner TERREWODE to apply validated quality of life (QoL) assessment tools and develop indicators and data collection tools for a joint study on the psychosocial reintegration of women with persistent fistula-related disorders. The protocol for this study was submitted and received IRB approval in the first half of FY 15/16 and the study has been underway during the second half of the year. The target sample of WDI was identified, with adequate representation of most priority regions in Uganda. Enrolled women have received initial training and will continue to receive the package of psychosocial support services being evaluated through the study. Study findings,

including recommendations regarding optimal tools for QoL assessment among fistula clients and WDI, will be available in FY 16/17.

FC+ also developed a partnership with UCSF/Makerere University to provide support for a study on reintegration after fistula repair in Uganda. FC+ is providing funding for the completion of study data collection and will collaborate with the UCSF/MU team on development of technical briefs/publications from study findings. This study will complement the findings of FC+'s own research on reintegration for WDI.

Towards the end of FY 15/16, FC+ has embarked on an effort to increase the knowledge base surrounding current facility-level intrapartum and postpartum clinical practices in managing prolonged/obstructed labor, focusing on postpartum urinary catheterization. A survey template and sampling plan were developed and it is expected that the survey will be finalized and circulated to the targeted audience in the first quarter of FY 16/17.

SECTION III: COUNTRY REPORTS

Please note: reports are provided only for objectives that were actively addressed in FY 15/16. All sub-objectives are consolidated for reporting.

Bangladesh

USAID-supported fistula services in Bangladesh began in July 2005 through the previous FC project and continue through FC+ in eight hospitals as of September 30, 2016. In Bangladesh, FC+ works with private hospitals and public sector institutions, including Medical College Hospitals and District Hospitals. The FC+ project is working in partnership with the Bangabandhu Sheikh Mujib Medical University (BSMMU) to set up a Fistula Prevention, Treatment and Training Center on-site. The project provides support to two prevention-only facilities and will expand support to a third facility in FY 16/17. During FY 15/16, site assessments were carried out at Jhalakathi and Hobiganj District Hospitals, as well as the HOPE Foundation Hospital as part of efforts to support and strengthen their fistula prevention activities. All currently supported fistula treatment sites in Bangladesh provide referrals to fistula clients for social and medical services and nearly all provide reintegration services.

Security concerns impacted movement throughout the country and therefore, program activities, in the latter part of the fiscal year.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+ collaborates in Bangladesh with UNFPA and the National Fistula Task Force Working Group (NFTWG) to strengthen the enabling environment and support institutionalization of fistula services in both the public and private sectors. The NFTWG met throughout the fiscal year, addressing a variety of fistula related issues. In the first quarter of FY 15/16, work to develop and gain approval for a National Obstetric Fistula Strategy culminated in printing and distribution of the recently finalized strategy, after receiving final permission from the Government of Bangladesh (GOB). A proposition was also put forward to provide fistula orientation to physicians taking calls at the MoH call center, to ensure that women inquiring with fistula-related symptoms get adequate information and referral.

FC+ Bangladesh continued collaboration with UNFPA to establish a meeting and a communications strategy for the NFTWG. UNFPA and FC+ discussed a wide variety of fistula-related issues, including upcoming conferences, obstetric care provided by community clinics, iatrogenic fistula, and WDI. These topics were addressed during a NFTWG meeting in the second half of FY 15/16, along with discussions on planning for International Day to End Obstetric Fistula commemoration which took place in the third quarter.

FC+ has continued working with various arms of the GOB, including the Quality Improvement Secretariat (QIS) of the Ministry of Health and Family Welfare (MOHFW). The QIS is responsible for setting standards of clinical and preventive care in the country and FC+ reached

out to the QIS to work together on quality improvement for management of female genital fistula. QIS hosted a meeting on fistula care in Bangladesh in May 2016, which included senior fistula surgeons, representatives of the National Fistula Center, UNFPA, MoH, the Obstetrical and Gynaecological Society of Bangladesh (OGSB) and other stakeholders. The meeting resulted in the formation of a technical panel to be chaired by Dr. Sayeba Akhter, professor and fistula surgeon at Dhaka Medical College and Hospital.

FC+ Bangladesh also collaborated with OGSB through participation in Fistula Sub-Committee meetings (first and second quarter) as well as through participation at OGSB's 24th International Scientific Conference in Cox's Bazaar (first quarter). During the conference, FC+/Bangladesh hosted a panel discussion on "Female Genital Fistula" and a press workshop entitled "Media Leader Workshop on Fistula Communication" which addressed fistula prevention, identification, and treatment. The panel was co-hosted by the University Fistula Center of BSMMU and the Hope Foundation for Women and Children of Bangladesh. Following the workshop, at least 22 editorials or articles have been published in national and local newspapers, as well as television interviews and two televised special programs on fistula and specific FC+ activities.

Media leader workshop on fistula communication, November 2015. Credit: N. Biswas

In addition to the OGSB conference, FC+ Bangladesh played a leading role in the organization and implementation of the HOPE Maternal Health and Fistula Conference 2016, held in Cox's Bazar March 19-20, 2016. Nearly 200 doctors, nurses, midwives, fistula surgeons, and fistula program staff attended the conference. The conference included a dedicated session on "Obstetric Fistula: State of Care in Bangladesh," chaired by Dr, Akhter whose attendance was supported by FC+. The FC+/Bangladesh Country Director presented a paper titled "Overview of Fistula Care *Plus* Project in Bangladesh" and Prof. Saleha Begum Chowdhury, Project Adviser of the FC+-supported University Fistula Center at BSMMU presented a paper on "An Overview of University Fistula Center." Dr. Halida Hanum Akhter presented a paper on "Mobilization of Fistula through NHSDP Surjer Hashi (SH) Clinics."

As described under Objective 5 and in Section II, FC+ worked closely in FY 15/16 with Save the Children, MaMoni and other stakeholders of the Bangladesh Maternal Mortality and Morbidity Survey (BMMMS) to ensure coordination of activities, including the establishment of a follow-

up clinical examination and referral protocol for suspected fistula and prolapse cases identified through the BMMMS process.

In March 2016, the new president of EngenderHealth, Ulla Muller, visited the University Fistula Center at BSMMU and Kumudini Hospital. Her visit received both electronic and print media coverage.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+ continued to reinforce partnerships with both facilities and communities to strengthen efforts towards fistula prevention, treatment, and reintegration. FC+ also continued its work with the NGO Bangladesh Rural Advancement Committee (brac) to build a partnership for fistula case identification and referral. In addition to working with brac, FC+ has built a partnership with the NGO Health Service Delivery Project (NHSDP) for patient identification screening and referral.

Fistula orientation conducted by brac in Faridpur, November 2015. Credit: A. Rahman

During FY 15/16, a total of 442 in-person community outreach/education/advocacy events were carried out for community members, health providers, and local officials. These activities included FC+ and brac-run orientation programs for community volunteers, community skilled birth attendants, and district health officials covering topics related to fistula prevention (including FP), identification, treatment and reintegration. FC+/Bangladesh conducted orientation programs for health providers including community-based skilled birth attendants, doctors, nurses, and midwives, as well as health officials and paramedics in Hobigonj, Jhalokathi, Lalmonrihat, Rangpur, Kurigram, and Cox's Bazar districts.

Nearly 8,000 participants were reached through these in person community outreach, education, and advocacy events while over 980,000 people were estimated to be reached via radio broadcasts. Information on community events, by type, is presented in Table BGD1. Screening camps were also held in multiple districts prior to each concentrated repair effort. During FY 15/16, FC+ partner brac carried out a total of ten community-based fistula diagnostic events (CFDEs), together with FC+/Bangladesh and NHSDP, during which 128 women with fistula were identified and referred for surgery, as well as numerous women with third and fourth degree perineal tears.

Community-based fistula diagnosis event at Mymenshing, December 2015. Credit: Sk. N. Huda

The partnership with brac is innovating fistula case finding through the use of a four question (4Q) checklist as a screening tool used by brac community health workers to conduct house-to-house screening to identify suspected fistula and complete perineal tear (CPT) cases. The house-to-house approach uses context-appropriate methods to address the realities of women's lives, particularly barriers women with fistula face including stigma, isolation, limited mobility, and limited literacy. The house-to-house screening is sensitive to the physical, economic, and sociocultural barriers to mobility that many women face, particularly in rural or underserved areas. In the second quarter, FC+ met with brac to plan field testing for the 4Q checklist, which took place in the third quarter in Faridpur District.

4Q Checklist launch in Faridpur District, May 2016. Credit: Nitta Biswa

In Bangladesh, there is anecdotal evidence that fistula may be additionally stigmatized due to perceived association with sexual violence, further depressing care-seeking. By deploying female community screeners knowledgeable on both the 4Q checklist and the local context, brac and FC+ bring information and referral to women in their own homes, to identify previously isolated women with fistula symptoms and provide linkages to care. Because of brac's ability to reach every house in a community, the Bangladesh activity may also enable local, population-level estimates of fistula and complete perineal tear burden for the first time. FC+ will share the 4Q checklist and the screening approach at the ISOFS conference in October 2016, and will disseminate prevalence estimates generated through this screening later in FY 16/17.

Table BGD1: Community Outreach/Education/Advocacy Events, By Quarter, FY 15/16

Type of Event	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Existing community activity	2	1,133	0	0	0	0	3	110	**5**	**1,243**
Health facility	1	124	1	40	5	558	2	94	**9**	**816**
Health providers	147	2,140	115	1,545	158	1,918	0	0	**420**	**5,603**
Policy makers	2	205	0	0	0	0	0	0	**2**	**205**
Maternal health/ fistula-focused	1	35	0	0	0	0	5	44	**6**	**79**
Radio/TV	0	0	0	0	30	980,024	0	0	**30**	**980,024**
Total	**153**	**3,637**	**116**	**1,585**	**193**	**982,500**	**10**	**248**	**472**	**987,970**

During the fiscal year, Kumudini and LAMB provided training for 48 women, who had received fistula services, as community fistula educators. Topics covered in the training included fistula prevention, accessing available repair services, opportunities for skills development, and understanding the role of a community fistula educator; see Table BGD2.

Table BGD2: Community Volunteer/Educator Training, Participants by Topic, FY 15/16

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
Cured fistula clients skills training and education	30	0	8	10	**48**
Total	**30**	**0**	**8**	**10**	**48**

Several activities took place in Bangladesh as part of efforts to commemorate IDEOF in May 2016 (see Appendix U for a full summary of all FC+ IDEOF activity). These included a celebration with surgeons and patients at BSMMU and Ad-Din Khulna, a presentation on the importance of safe maternity care, and a seminar and live fistula surgery demonstration for trainee surgeons at the National Fistula Center.

Bangladesh staff members attended the SBCC Summit and Objective 2 Experts' workshop held in Ethiopia in February 2016.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

During FY 15/16, clinical monitoring and site assessments were carried out at all eight FC+ supported fistula repair sites, with follow-up visits taking place at sites in the second and third quarters. One particular area of emphasis during these visits was ensuring visibility at the site for specific fistula and FP counseling areas. FC+/Bangladesh printed medical waste management and surgical hand washing job aids that were distributed to all supported sites in the second quarter, and fistula counseling checklists in Bangla that were disseminated to all treatment sites in the fourth quarter. Reference guidelines including WHO ICU and anesthetic care guidelines,

fistula and FP counseling guides, and EmOC care materials were also distributed to supported sites.

FC+/Bangladesh met with the USAID Dhaka Activity Manager to discuss plans to introduce fistula services at three district hospitals: Jhalokhati, Moulvibazar or Hobigonj, and Jhenaidah or Rajbari. Following this, a visit was conducted at Jhalokathi Hospital in February 2016 to introduce prevention/limited curative services at this facility. Given the lack of fistula services available in southern districts of Bangladesh, introduction of services at Jhalokhati will help to meet the needs of this region.

During FY 15/16, 668 women with severe incontinence symptoms sought fistula care services at FC+ supported sites, of which 375 were diagnosed with fistula (56%). FC+ supported 273 surgical fistula repairs during this period (80% of the 340 women who were diagnosed with fistula and medically eligible for surgery).

Some women may be diagnosed with fistula in one quarter and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure BGD1 presents data on women seeking and eligible for fistula treatment, and the number of fistula surgeries supported, by site.

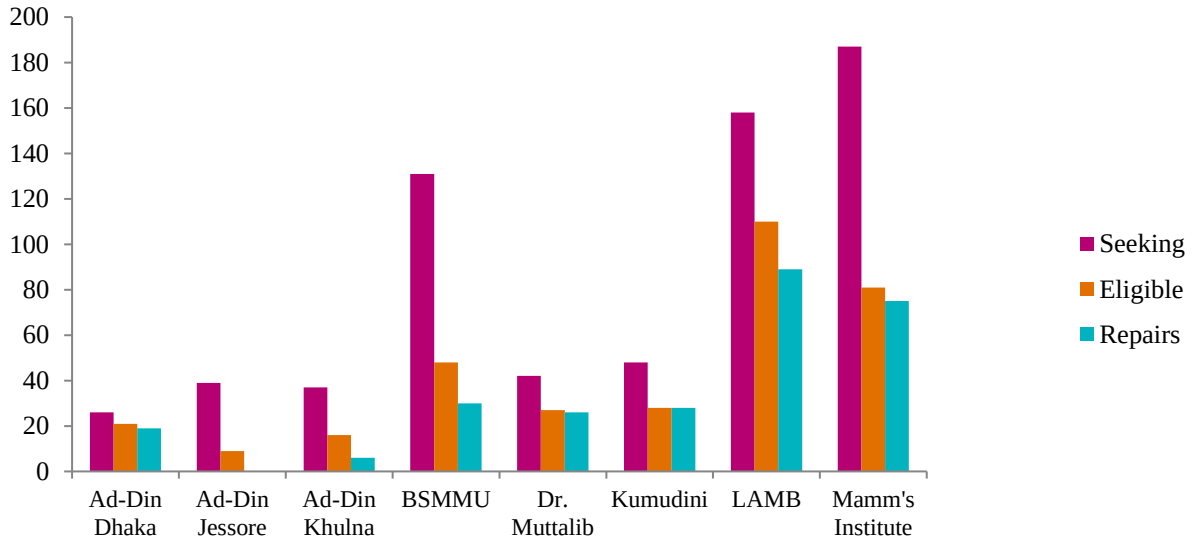
These 273 fistula repair surgeries were conducted at seven FC+ supported hospitals: Ad-Din Dhaka, Ad-Din Khulna, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dr. Muttalib Community Hospital, Kumudini, LAMB, and Mamm's Institute of Fistula and Women's Health (see Table BGD3 for detail by quarter)[9]. The fourth quarter saw a decrease in repairs due to security concerns that restricted movement of both patients and providers.

In addition to the surgical repairs supported, three women received conservative treatment (catheterization) for fistula during the fiscal year (one at BSMMU and two at LAMB), with one of the cases closed and continent at discharge and the other two requiring further treatment.

There were two concentrated repair efforts held at LAMB in the first half of FY 15/16 and one held at Ad-Din Khulna in the third quarter, during which some of the more complicated cases were able to undergo repair surgery. 27% (n=75) of all surgeries performed during this time period occurred during concentrated efforts

[9] Ad-Din Jessore screened and referred women for repairs, but did not conduct any fistula surgical repairs during the fiscal year.

Figure BGD1: Number of Women Seeking and Requiring Fistula Treatment, and Number of Surgical Repairs, by Site, FY 15/16



Etiology data was available for 341 of the diagnosed fistula cases. Just over half of fistula diagnosed were the result of prolonged/obstructed labor (57%), followed by iatrogenic causes (36%). 3% of diagnosed fistula were the result of traumatic causes and the remaining "other" etiology was cancer-related. The proportion of fistula deemed iatrogenic varied by site, with a low of 11% at Dr. Muttalib Community Hospital to highs of 50% at Ad-Din Dhaka, 43% at Kumudini, and 42% at LAMB.

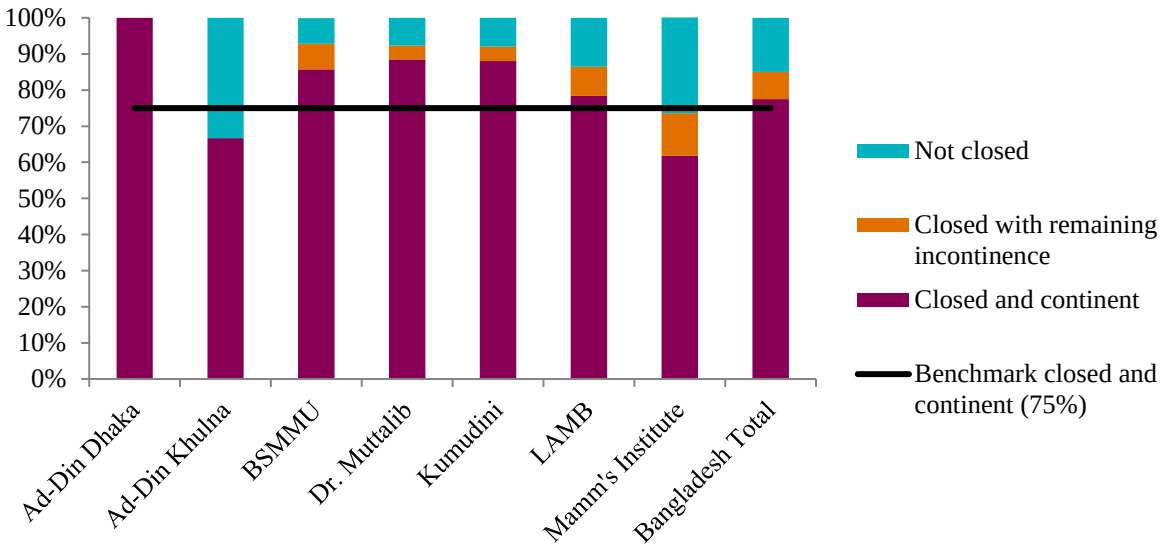
Table BGD3: USAID-Supported Surgical Fistula Repairs, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Ad-Din Dhaka	5	8	2	4	**19**
Ad-Din Jessore	0	0	0	0	**0**
Ad-Din Khulna	0	0	6	0	**6**
BSMMU	6	12	6	6	**30**
Dr. Muttalib	11	6	4	5	**26**
Kumudini	14	7	4	3	**28**
LAMB	43	20	20	6	**89**
Mamm's Institute	17	24	20	14	**75**
Total	**96**	**77**	**62**	**38**	**273**

Discharged fistula repairs during FY 15/16 were nearly evenly split between simple and not simple cases (52% and 48% respectively). 85% of all fistula surgery cases in FY 15/16 were closed at discharge; with 77.5% closed and continent and 7.5% closed and incontinent. 15% were not closed at discharge. Outcomes for discharged patients are presented, by site, in Figure BGD2. Reported complications were low at supported sites (4% overall) with a range of 0%

(Ad-Din Dhaka, Ad-Din Khulna, Dr. Muttalib Community Hospital, and Kumudini) to 21% (BSMMU)[10].

Figure BGD2. Outcome Rates for Surgical Repairs, by Site, FY 15/16



During FY 15/16, six surgeons from three facilities received training in fistula surgical repair: five received first training and one received continuing training (see Table BGD4 for detail, by trainee home institution).

Trainee surgeons with the new President of EngenderHealth, March 2016. Credit: PK Poddar

Table BGD4: Surgical Fistula Repair Training, Participants by Trainee Institution, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	1st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont
Bangladesh DGHS	0	1	0	0	0	0	0	0	0	1
BSMMU	0	0	3	0	0	0	0	0	3	0
LAMB	0	0	0	0	2	0	0	0	2	0
Total	**0**	**1**	**3**	**0**	**2**	**0**	**0**	**0**	**5**	**1**

10 During the FY, six of the 28 cases discharged experienced post-operative complications.

As part of fistula prevention efforts, FC+/Bangladesh provided training to 83 health personnel during FY 15/16. These included trainings in pre- and post-operative fistula care, FP and fistula counseling, and infection prevention. Table BGD5 provides additional detail on non-surgical trainings for health system personnel.

Table BGD5: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Pre- and post-operative care	6	0	7	0	**13**
Infection prevention	0	0	0	40	**40**
Fistula and FP counseling	0	0	0	12	**12**
Fistula identification and overview	0	0	0	18	**18**
Total	**6**	**0**	**7**	**70**	**83**

FC+ supports FP counseling and service provision at most supported sites in Bangladesh. During FY 15/16, 26,769 counseling sessions took place at supported sites and 17,971 CYP were provided; see Table BGD6 for detail, by site. Method mix in Bangladesh is primarily comprised of IUCD (Copper T- 4% of CYP), Implanon (8%), oral contraceptives (9%), Depo (10%), and tubal ligation (64%).

During the third quarter of the fiscal year, FC+/Bangladesh introduced a "family planning referral slip" at all FC+ fistula treatment sites, in addition to provider job aids for FP counseling and delivery checklists to ensure fistula clients' FP needs are being met and rights are respected.

Table BGD6: Family Planning Counseling Sessions and CYP, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP[11]
Ad-Din Dhaka	3500	2,229	3300	1,641	3900	1,944	4000	2,138	**14,700**	**7,952**
Ad-Din Jessore	770	349	1095	306	0	0	0	0	**1,865**	**655**
Ad-Din Khulna	50	318	300	324	400	306	410	645	**1,160**	**1,592**
BSMMU	500	243	1200	445	NA	420	400	493	**2100**	**1,601**
Dr. Muttalib	120	96	83	16	71	70	78	58	**352**	**240**
Hope	0	0	980	18	593	3	944	2	**2,517**	**23**
Kumudini	385	638	420	617	340	462	430	566	**1,575**	**2,283**
LAMB	1800	857	100	910	400	818	200	1,041	**2,500**	**3,625**
Total	**7,125**	**4,729**	**7,478**	**4,276**	**5,704**	**4,022**	**6,462**	**4,943**	**26,769**	**17,971**

[11] Due to rounding, totals may differ slightly from the sum of individual quarters.

FC+ supported sites reported an overall C-section rate of 66% during the fiscal year. Information on number of deliveries, by site, is represented in Figure BGD3 and C-section rates, by site, are presented in Figure BGD4.

Figure BGD3. Number of Obstetric Deliveries, by Site, FY 15/16 (n=27,713)

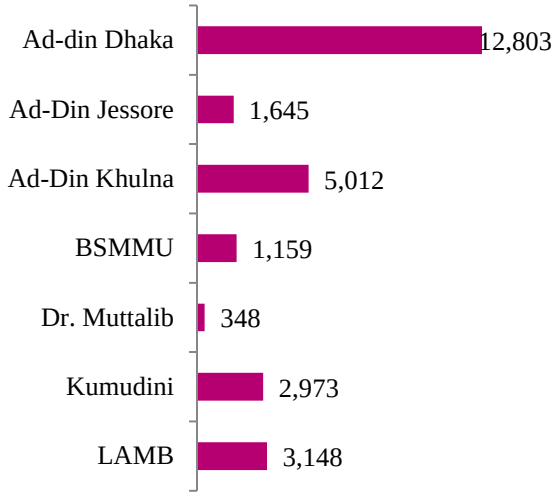
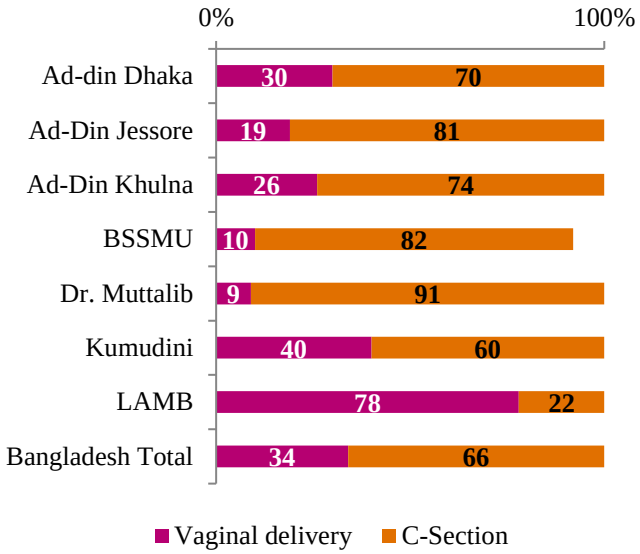


Figure BGD4. C-Section Rates, by Site, FY 15/16



Seven FC+ supported facilities report current use of catheterization as a prevention intervention following prolonged/obstructed labor. Very few deliveries were reported as being prolonged/obstructed (0.3%) but of those reported 93% received catheterization as a preventative method.

Partograph monitoring was carried out at six supported facilities during the fourth quarter. Following the visits, reports were developed and shared with each site providing a summary of findings.

Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

Following input on design and data collection tools from the FC+ Bangladesh and Global teams, the BMMMS began in FY 15/16 with implementing partners including GOB, USAID, ICDDRB, Measure Evaluation, Save the Children, and FC+. This survey aims to generate more specific data on maternal mortality and morbidity, including genital fistula and genital prolapse. FC+'s primary role during survey implementation is to ensure case diagnosis through community-based fistula and prolapse diagnosis events. During the second quarter, FC+ participated in a meeting hosted by USAID at ICDDRB during which the implementation of the survey was discussed, as well as FC+'s role as a key implementer through diagnosis at the community level and provision of fistula repair for identified cases

During FY 15/16, FC+ continued efforts to organize a partners' forum to provide a platform for exchanging lessons learned and discussing cross-cutting issues in fistula program implementation. This forum will include both government and private partners and is expected to take place during the beginning of FY 16/17.

As mentioned under Objective 2, FC+ Bangladesh worked with brac to strengthen their reporting system and record keeping for fistula patients during the first quarter of FY 15/16. Data quality assurance (DQA) visits were conducted at all supported sites, as well as routine quarterly DDMs prepared by FC+ Bangladesh and shared with supported treatment facilities.

FC+ Bangladesh staff presented at both the FIGO World Congress (three presentations) and the Global Maternal and Newborn Child Health Conference (one presentation) in October 2015.

During FY 15/16, 100% of supported treatment sites were able to meet at least once to review data and utilize it for planning and decision-making; 80% of sites (all but Ad-Din Jessore) were able to meet at least twice.

Democratic Republic of Congo

USAID-supported fistula services in DRC began in 2008 through the previous FC project and continue through FC+ in five hospitals as of September 30, 2016. USAID also provides bilateral support to the Projet de Santé Integré (ProSani) for mobile outreach fistula repair efforts in DRC. The EngenderHealth office in Kinshasa is shared with the BMGF-funded project, ExpandFP.

In DRC, FC+ has partnered with health centers and hospitals to support fistula repairs, train doctors and nurses in fistula-related skills and topics, improve EmONC, and conduct outreach to rural clinics to ensure that women in need of medical attention are referred to the hospitals for repair.

The city of Beni and its surroundings remain subject to insecurity due to violence in the area. This permanent instability and insecurity cause frequent displacements of the population.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+/DRC has been part of ongoing efforts to develop a National Strategy for Fistula in DRC. To promote policy level support for the national fistula strategy and coordination of activities that can support fistula prevention, FC+/DRC Senior Program Manager Michel Mpunga has attended all MOH Task Force meetings on maternal and neonatal health.

One partners' meeting was held in Bukavu in the first quarter of FY 15/16 to facilitate communication, data review, and program planning. Subaward reviews and planning for follow on were conducted. FC+/DRC interviewed several clinical officers for a full time position on the team and hired Dr. Felicien Banze for this position in the fourth quarter. Having a full time physician on staff will strengthen the clinical tracker and checklist system implementation, facilitate routine and interval site assessments and permit accelerated, streamlined clinical functions between FC+/DRC and the global team, as well as FC+/DRC and other FC+ country offices.

FC+/DRC continues to participate in the SMNE Task Force (Santé de la Mère, du Nouveau né et de L'Enfant – Maternal, Newborn and Infant Health) along with experts from the MOH and professionals working in the field of MNCH and fistula. The Task Force has provided a platform for reflection, designing standards and guidelines, and monitoring activities and progress. The dissemination of the standards and guidelines of Maternal, Neonatal, and Child Health (MNCH) across the country began in earnest in the beginning of FY 15/16 and included trainings in both the central and provincial health divisions. FC+ contributed to these efforts by disseminating the standards and guidelines to supported sites. Plans to conduct trainings at SJH and Kisenso in the new guidelines have been postponed to FY 16/17 due to delays in coordination by SMNEA.

Efforts to create a specific working group within the Task Force, focused on the fight against fistula, have been repeatedly delayed. As a result, FC+ DRC organized a second partners' meeting in Goma in August 2016 to revitalize these plans. The Task Force will also work towards establishing a national strategic plan in the fight against fistula and try to reach

consensus on various definitions in fistula classification. A meeting took place in September 2016 between FC+, the D10 (10th Health Directorate: Family and Specific Groups), and the National Reproductive Health Program to prepare for the establishment of the working group.

Supported sites have also directly leveraged funds from their own partners to complement the activities they are able to do with FC+ funds. In Kinshasa, partner repair site St. Joseph Hospital (SJH) constructed a hospital ward with ten beds for women with fistula through partnership with the "Kin Accueil" association. FC+ and USAID were able to donate an additional 44 beds to the ward and the hospital also received equipment from the CURE Project. The Belgian NGO Médecins Sans Vacances collaborates with SJH on repairs campaigns. In Goma, Heal Africa has several partnerships with the World Bank; Healing Arts, Christopher Blind Mission, and the World Food Program (WFP). In Maniema province, MSRK/IMA and Caritas have worked as partners, as part of the DfID-funded ASSP project that includes a component for fistula treatment.

HEAL Africa and Panzi have an ongoing partnership with World Bank through the Social Fund of the DRC for the integrated management of survivors of sexual and gender based violence (SGBV) who have symptoms of prolapse or fistula. This partnership includes coverage of treatment and mental health care costs for women who are survivors of sexual violence and suffer from prolapse or fistula, supplies post-exposure prophylaxis kits to the hospitals, supplies rural health centers with essential drugs, and legal assistance to women. Maison Dorcas, at Panzi Hospital, also provides support for survivors of SGBV and children borne from rape who may be rejected and marginalized by their communities, as well as providing resources for socio-economic reintegration including training and income generating activities for psychosocial support.

SJH has worked to develop private partnerships with various local resources, including a local psychologist who provides counseling on a volunteer basis, donation of fabric to make dresses for fistula clients, and an NGO in Kikwit who offered accommodation in its reception center for clients who arrive early for outreach repair efforts and need somewhere to stay.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

During FY 15/16, FC+ supported sites in DRC carried out 45 in-person community outreach efforts reaching 5,369 people, see Table DRC1. An additional six mass media outreach efforts were undertaken during the fiscal year, but broadcast reach estimates were unavailable.

These in-person outreach efforts included advocacy and education in churches carried out by IGL, MSRK, and St. Joseph Hospital. IGL organized educational and awareness sessions reaching men, women, and adolescents with messages about fistula, social and behavioral change related to maternal health careseeking behavior, and addressing sexual violence. IGL also continued its partnership with local community radio channels for awareness raising about fistula prevention and service delivery.

Dr. Dolores Nembunzu and attendees of a community meeting. Credit: FC+/DRC

MSRK worked with schools to advance awareness and advocacy among female high school students, focusing specifically on FP and the harmful effects of early marriage and pregnancy. MSRK also organized radio programs that advocated for men as partners in the fight against fistula and the importance of fighting stigma and discrimination against women with fistula.

Panzi organized sessions at four universities in Bukavu on fistula prevention and management, as well as outreach events in Kayumu (in collaboration with CEPAC Christians and members of Kayumu Solidarity), Zongo, and Gemena. SJH aired a television program in the second quarter dedicated to women with fistula and addressing its social causes and resulting stigma as well as a radio programs in the second and third quarters as part of client recruitment efforts.[12] SJH also held awareness raising sessions with Army and police staff, as well as students, teachers and community members.

HEAL has held community outreach events reaching schools and religious leaders, as well as community advocates.

Activities took place in four sites in DRC (MSRK, Panzi, SJH and IGL) as part of efforts to celebrate the International Day to End Fistula (IDEOF) in May 2016 (see Appendix U for a full summary of all FC+ IDEOF activity). Awareness raising events and broadcasts

Celebration of IDEOF in Kindu, May 2016. Credit: FC+ DRC.

[12] Broadcast estimates of listening/viewing audiences could not be obtained.

were held with a focus on messaging related to improving access to treatment, male involvement, FP and the fight against stigma for those with fistula.

Table DRC1: Community Outreach/Education/Advocacy Events, By Quarter, FY 15/16

Type of Event	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Existing community activity	12	806	0	0	0	0	0	0	**12**	**806**
Health facility	0	0	0	0	0	0	1	50	**1**	**50**
Health providers	0	0	1	29	0	0	3	34	**4**	**63**
Policy makers	0	0	0	0	0	0	0	0	**0**	**0**
Maternal health/ fistula-focused	2	100	5	2,432	12	1,619	9	299	**28**	**4,450**
Radio/TV	2	n/a	2	n/a	1	n/a	1	15,000	**6**	**15,000**
Total	**16**	**906**	**8**	**2,461**	**13**	**1,619**	**14**	**15,383**	**51**	**20,369**

Three local CBO staff participated in an infection prevention training carried out by St. Joseph Hospital during the first quarter (see Table DRC2 as well as Objective 4).

Table DRC2: Community Volunteer/Educator Training, Participants by Topic, By Quarter, FY 15/16

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
Infection Prevention	3	0	0	0	3
Total	**3**	**0**	**0**	**0**	**3**

Two staff members from partner sites Heal Africa and Panzi attended the SBCC Summit and Objective 2 Experts' workshop held in Ethiopia in February 2016.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

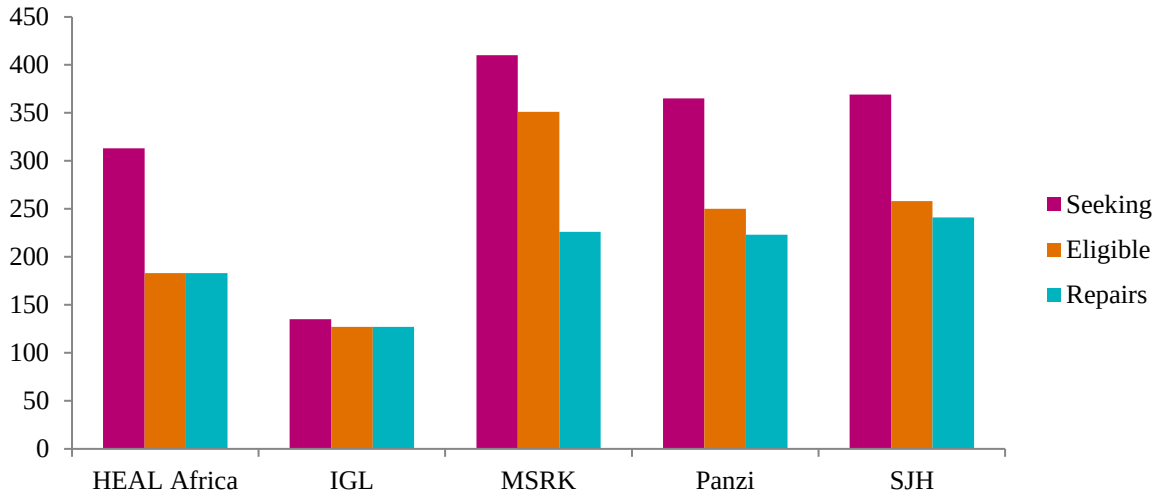
Clinical monitoring and waste management reviews were conducted at HEAL and Panzi during the fourth quarter of FY 15/16.

During FY 15/16, 1,592 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 1,265 were diagnosed with fistula (80%). Of the 1,265 diagnosed fistula cases, 1,169 were medically eligible for surgical repair (92%). FC+ supported 1,000 fistula repair surgeries during this period (86% of those eligible). Some women may be diagnosed with fistula in one quarter,

65 year-old SJH fistula client celebrates being dry after living with fistula for 50 years. Credit: FC+/DRC

and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure DRC1 presents data on women seeking and requiring fistula treatment, and the number of fistula surgeries supported, by site.

Figure DRC1: Number of Women Seeking and Eligible for Fistula Treatment, and Number of Surgical Repairs, by Site, FY 15/16



These 1,000 fistula repair surgeries were conducted at five FC+ supported hospitals: HEAL Africa, IGL, MSRK, Panzi, and SJH, see Table DRC3 for detail by quarter. 519 of these repairs (52%) were provided via routine service provision, with 481 repairs (48%) carried out via outreach efforts. Panzi and Heal Africa focused specifically on outreach repair efforts in the third quarter, with significantly higher numbers of repairs supported for that period. The number of supported repairs dropped in the fourth quarter as supported sites reached their subaward benchmarks. Panzi and Heal Africa also provided repairs to clients using other funds, which are not reported here. In the fourth quarter, Panzi was supported by the World Bank for providing repairs, so no FC+ supported repairs took place.

In addition to the surgical repairs reported here, a total of seven women received conservative treatment (catheterization) for fistula: six at IGL, one at HEAL Africa, all of whom were closed and continent at discharge. In addition to these FC+ supported repairs, Hôpital General de Référence (HGR) Kaziba provided 240 surgical repairs and five conservative treatments through the ProSani project, bilaterally funded by USAID.

Information on the etiology of diagnosed fistula was available for 100% of diagnosed cases (n=1,265). Of those cases, 61% were identified as being caused by obstructed or prolonged labor; 26% identified as iatrogenic in nature; 12% identified as having a traumatic etiology; and 2% due to congenital fistula or cancer.

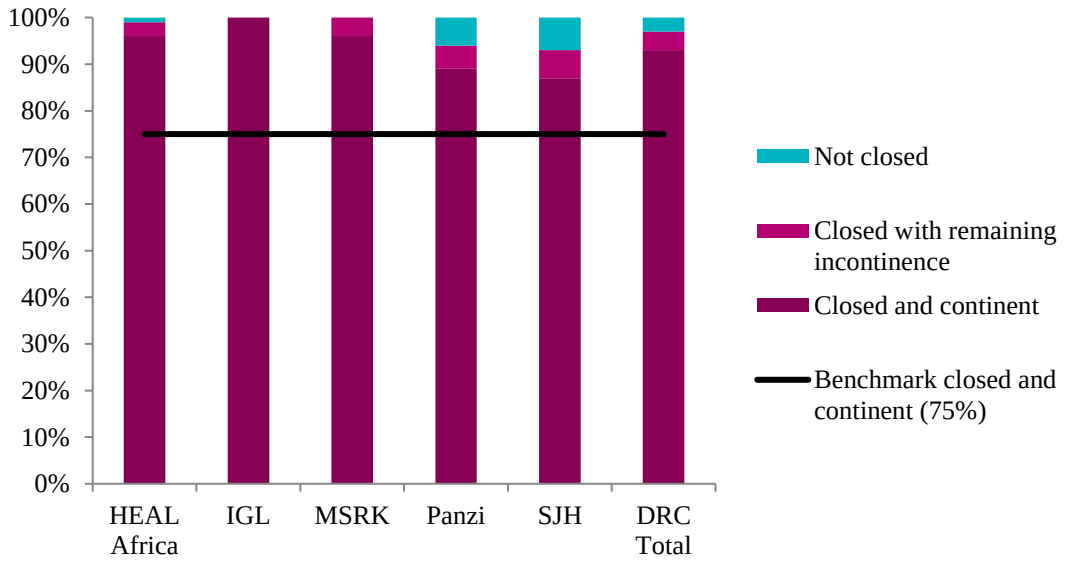
Table DRC3: USAID-Supported Surgical Fistula Repairs, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
HEAL Africa	40	18	112	13	**183**
IGL	37	35	30	25	**127**
MSRK	12	55	70	89	**226**
Panzi	0	21	202	0	**223**
SJH	45	34	91	71	**241**
FC+ Total	**134**	**163**	**505**	**198**	**1,000**
HGR Kaziba (ProSani)	60	60	60	60	**240**
USAID-supported Total	**194**	**223**	**565**	**258**	**1,240**

A total of 948 fistula cases were discharged during the first two quarters of FY 15/16. 64% (n=610) were classified as simple fistula and 36% (n=338) as not simple. 97% of all discharged fistula surgery cases were closed at time of discharge: 93% were closed and continent and 4% were closed and incontinent. Outcomes for discharged patients are presented, by site, in Figure DRC2. Reported complications were low at supported sites (<1% overall) with a range of 0% (HEAL Africa, IGL, MSRK, and Panzi) to 4.5% (SJH).

SJH outreach repair effort at Pay Kongila. Credit: FC+ DRC.

Figure DRC2. Outcome Rates for Surgical Repairs, by Site, FY 15/16



During FY 15/16, there were three surgeons trained at SJH; one receiving first training and two participating in continuing training, see Table DRC4. FC+ also supported participation of two clinicians from DRC at the July 2016 UroDak conference, which included a focus on complex fistula training.

Table DRC4: Surgical Fistula Repair Training, Participants by Trainee Institution, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16		Total # Surgeons
	1st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont	Total
SJH	0	0	1	2	1	1	0	0	1	2	3[13]
Total	**0**	**0**	**1**	**2**	**1**	**1**	**0**	**0**	**1**	**2**	**3**

As part of fistula prevention and treatment efforts, FC+ in DRC has provided training on a variety of topics to 234 health care providers during the fiscal year; see Table DRC5. Training covered infection prevention, antenatal care (HEAL, IGL, MSRK and SJH), and pre- and post-operative fistula care, including counseling. Two physical therapists conducted a site assessment of Panzi hospital to ascertain available services and gaps. During the visit, they reoriented the current clinical staff at Panzi to physiotherapy services across disciplines and provided staff with an introduction to the scope of physiotherapy practice, basic functional anatomy, and general exercise guidelines, all with regard to integrated pelvic floor rehabilitation.

Table DRC5: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Infection prevention	34	14	0	0	**48**
Pre- and post-operative care	0	0	14	0	**14**
Antenatal care, AMTSL and partograph	0	0	23	117	**140**
EmONC	0	0	0	32	**32**
Total	**34**	**14**	**37**	**149**	**234**

FC+/DRC supported FP counseling and service provision at four supported sites in DRC (all but IGL). During FY 15/16, over 7,000 counseling sessions took place at these supported sites and 4,939 CYP were provided (see Table DRC6 for detail, by site). A rapid assessment conducted in the fourth quarter indicated that only two of the five supported treatment sites (Panzi and HEAL Africa) have well-functioning FP services, and plans are underway to revitalize provider training and resolve supply issues at the remaining sites.

Group counseling at SJH. Credit: FC+ DRC.

[13] One surgeon participated in first training that spanned the second and third quarters, and another surgeon participated in continuing training that spanned the second and third quarters. Therefore, the total number of surgeons trained during FY15/16 is three.

Table DRC6: Family Planning Counseling Sessions and CYP, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP[14]
HEAL Africa	33	218	2	281	36	272	24	332	**95**	**1,103**
IGL	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	**n/a**	**n/a**
MSRK	2	20	227	76	134	34	46	14	**409**	**144**
Panzi	529	630	43	451	38	522	38	587	**648**	**2,190**
SJH	2,523	900	645	599	1,577	604	1,128	399	**5,873**	**2,502**
Total	**3,087**	**1,767**	**917**	**1,408**	**1,785**	**1,432**	**1,236**	**1,332**	**7,025**	**5,939**

In the fourth quarter, training efforts focused specifically on AMTSL and partograph, see Table DRC5. FC+ supported sites reported an overall C-section rate of 33% in FY 15/16, with a total of 10,732 deliveries. Information on number of deliveries, by site, is represented in Figure DRC3 and C-section rates, by site, are presented in Figure DRC4. 7% of reported deliveries were prolonged/obstructed labor and of those, 19% received catheterization for fistula prevention.

Figure DRC3. Number of Obstetric Deliveries, by Site, FY 15/16 (n=10,732)

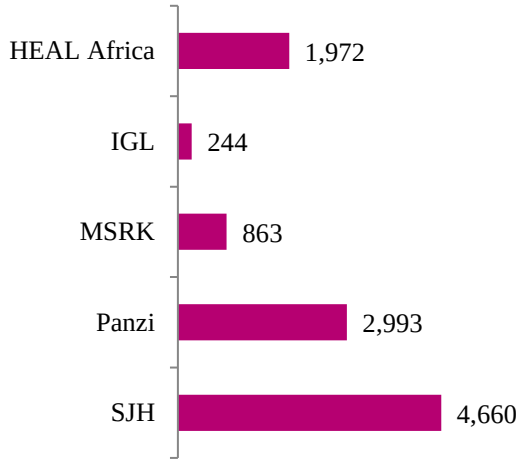
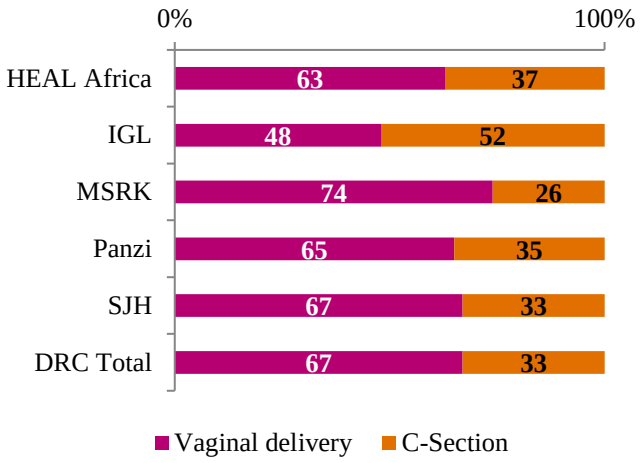


Figure DRC4. C-Section Rates, by Site, FY 15/16



Partograph monitoring visits were conducted at four supported facilities during the third quarter (SJH, Kisenso, HEAL Africa and MSRK) during which feedback and discussion on record-keeping and use of the partograph took place.

[14] Due to rounding, totals may differ slightly from the sum of individual quarters.

Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

During the first half of FY 15/16, FC+/DRC supported partner presentations at several conferences including GMNHC, PAUSA, a roundtable on adolescent health in Kinshasa, FIGO, and SCOGO. FC+/DRC's research agenda is under development. Draft protocols should be ready for review in the next reporting period, and are expected to address increased proportions of iatrogenic fistula cases identified in outreach settings, trends in POP services since initiation of external funding for POP surgery, and assessment of the impact of fistula on female sexual function in Eastern DRC.

The project additional plans to conduct a retrospective and prospective study on the etiology, means of diagnosis, and treatment of non-obstetric genital fistula in the coming year. Research will be preceded by the development of a protocol during a meeting in Kinshasa, the training of investigators and supervisors in the protocol and their roles/responsibilities, followed by data collection at the sites. Each site will appoint a local investigator and an assistant and the overall process will be supervised by FC+ Global Team. Additionally, FC+ will complement clinical quality assurance and capacity building activities with targeted facility-level special studies to address knowledge gaps identified by the project and/or our clinical partners.

During FY 15/16, 80% of supported treatment sites (all sites but Panzi) were able to meet at least once to review data and utilize it for planning and decision-making; 60% of sites (SJH, HEAL and MSRK) were able to meet at least twice.

Nigeria

USAID-supported fistula services in Nigeria began in 2007 through the previous FC project and continue through FC+ in 15 treatment and prevention sites and 768 prevention-only sites, including 500 sites inherited from the former TSHIP project, as of September 30, 2016. FC+ currently works in 15 states in Nigeria: Akwa Ibom, Bauchi, Cross River, Ebonyi, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kwara, Oyo, Plateau, Sokoto, Zaria, and Zamfara. FC+ fistula prevention and treatment efforts in Nigeria have focused on support for repairs, clinical training, improving emergency and basic obstetric care, integration of FP services, community awareness efforts, and advocacy at the national and state levels.

Supported sites in Nigeria encountered challenges during FY 15/16 related to inadequate human resources to provide care during and after repairs, including both systemic problems as well as physician strikes in both Oyo and Kwara States. FC+/Nigeria continues to advocate among stakeholders for the engagement of additional staff and will continue to do so until this situation is addressed. Lack of streamlined and coordinated rehabilitation and reintegration programs is also a challenge and FC+ is working with other implementing partners to address this.

In the second quarter, FC+/Nigeria assessed the possibility of adding support to additional fistula centers. Following assessment and discussion, in the third quarter FC+ Nigeria initiated support for fistula prevention and treatment services to three sites: Pope John Paul II Family Life Centre VVF and Maternal Injuries Hospital in Akwa Ibom, Evangel VVF Center, Jos in Plateau, and Hajiya Gambo Sawaba General Hospital in Zaria. Additional sites are currently being considered for FY 16/17 support in Makurdi (Benue State), Damaturu (Yobe State), and Yola (Adamawa State).

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

Throughout FY 15/16, FC+ has reached out to key stakeholders at various levels of government and traditional institutions to advocate for more quality, attention, and resource allocation for fistula prevention, treatment, and reintegration in Nigeria. These efforts have included advocacy and collaboration with the FMOH as well as many key national ministries and state level ministries in all supported states.

FC+/Nigeria's clinical team launched pilot implementation of new program client tracker and safety checklist tools and were instrumental in fashioning the FC+ Surgical Safety Toolkit that includes an "admission to discharge" series of clinical checklists designed for versatile implementation as guidelines or protocols, or as actual chart documentation. Nigeria has also finalized a Client Documentation Booklet, a bound, comprehensive medical record, that is under review for final approval by the FMoH. This booklet incorporates the principles of and harmonizes functions with the new Surgical Safety Toolkit of clinical trackers and checklists, and is also based on a similar document developed by Uganda under the prior Fistula Care

project. The clinical team also worked with FC+/Nigeria fistula treatment teams to design anesthesia training to backstop gaps in anesthesia capacity that were evident on country visits.

During the fiscal year, FC+/Nigeria carried out work to support the government regarding policy development including technical input and advocacy for the adoption of the technical guidelines for conservative treatment (through catheterization) of fistula, short-duration catheter use after fistula repair, the algorithm for management of survivors of sexual and gender-based violence (SGBV), and renewal and dissemination of the National Guidelines on SGBV in Nigeria. The guidelines on catheterization were approved by the Hon. Minister for Health late in the second quarter; and FMOH approval was officially granted during the fourth quarter. The guidelines will be launched at the ISOFS conference in Abuja in October 2016. FC+/Nigeria is also working with stakeholders and the FMOH to develop guidelines for the management of WDI. A draft has been produced and is being reviewed by experts for finalization. This document will serve as a model for other FC+ implementing countries.

Activities to celebrate the commemoration of the International Day to End Obstetric Fistula were held in Kebbi and Sokoto States in May 2016. The Project commissioned equipment, conducted radio programs, and conducted pooled fistula repair efforts. The wife of the Sokoto State Governor visited the Maryam Abacha Women and Children Hospital and donated items to fistula clients.

IDEOF celebration at Maryam Abacha Women and Children Hospital, Sokoto. Credit: FC+ Nigeria

FC+/Nigeria also distributed fistula and FP equipment and instruments to all supported states and fistula centers throughout the project year in order to address gaps identified during initial needs assessments. Commissioners of Health received the equipment on behalf of their states government in Kano, Jigawa, Sokoto, Kwara and Oyo state. The handovers provided the opportunity to advocate to the Heads of Ministries of Health for their states to include fistula services in the Saving One Million Lives program. All gave their promise of support, and the Commissioner for Health in Oyo State shared his blueprint of specific actions for the treatment and prevention of fistula. Equipment were handed over to Ebonyi State by the USAID Deputy Mission Director, Aler Grubbs, in a ceremony chaired by the Deputy Governor who received the items on behalf of the State Government.

FC+/Nigeria has also been working closely with the FMOH to develop and pilot new fistula registers that will be used nationally for data collection at fistula centers, and to amend the national HMIS system to capture additional indicators on fistula services, see Objective 5 for additional detail.

FC+/Nigeria undertook numerous advocacy and courtesy visits to government officials, ministries, and agencies in FY 15/16 including:

- Visits by the Global Project Director to sites in four states, including a meeting with the wife of the Governor of Ebonyi State as well as numerous policy makers and health officials. Discussions included new project initiatives including the piloting of POP work at National Obstetric Fistula Center (NOFIC) Abakaliki and the emphasis on prevention of obstructed labor in community messaging
- Advocacy visit to Her Excellency Mrs. Gimbiya Yakubu Dogara, wife of the Honorable Speaker of the House of Representatives, who previously attended the Providers' Network Meeting and subsequently has pledged support for consumables and food for fistula clients during pooled efforts
- Advocacy visits to the Chief Medical Directors of Fistula Centers in Kebbi, Zamfara, and Sokoto States and the Honorable Commissioner of Health in Sokoto
- A joint site visit with USAID/Nigeria to the Sobi Specialist Hospital in Kwara State, to advocate for more resources for the eradication of fistula and collaboration with University of Ilorin Teaching Hospital to improve human resources available for fistula services
- NGO community meeting with the Honorable Minister of Health during which the MOH shared their health plan and fielded suggestions from the NGO community. Meetings will be held quarterly going forward to review performance

FC+/Nigeria staff attended the October 2015 FIGO meeting and the FC+ Global Project Director made a presentation at the Society of Obstetricians and Gynecologists of Nigeria (SOGON) conference on Urogynaecology in Sub-Saharan Africa providing opportunity to share information about the project as well as learn from the efforts of others.

During the fourth quarter, FC+/Nigeria staff attended a stakeholders meeting for the Saving One Million Lives (SOML) Program, funded by the World Bank, which addresses MCH at the primary health care level throughout Nigeria. Individual states were encouraged to include development partners in their steering committees and FC+ was invited to be part of the committee in Sokoto State.

In collaboration with Radio Nigeria, FC+/Nigeria sponsored multiple awareness creation programs throughout the fiscal year, including media roundtables for journalists and advocacy meetings with Media Chiefs, dedicated to fistula and FP issues which resulted in increased media attention. During the third quarter, the project arranged for journalists to visit the NOFIC Abakaliki where they had the opportunity to meet with fistula clients and view the facility. A number of radio programs were carried out in supported States, including donated one-hour program slots from Express and Rahama radio. FC+/Nigeria also visited community partners in Katsina, including Katsina Radio and Companion FM, both of which gave the team radio time to discuss fistula causes, prevention, and treatment.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

During FY 15/16, FC+/Nigeria continued efforts to review the Nigeria communication strategy, building on the strategy used in the previous project, and identifying potential areas of improvement. A communications assessment study to identify current knowledge, sources of information, and available communication channels for messages related to fistula, maternal health, and FP, took place during the first two quarters. Research teams were identified and trained during the first quarter and the assessment was carried out in five states during the second quarter. Two study reports (one focused on qualitative data, the other on quantitative) have been drafted and are currently under review by the Nigeria USAID Mission. The process of developing a communication strategy for the project, based on the study findings, began in the fourth quarter. The strategy will be finalized by the first quarter of FY 16/17 and implementation will commence at that time.

In May 2016, the project organized a workshop in Kaduna to review and develop communications materials. Participants included Federal and State government staff as well as other key partners such as fistula clients, health providers, religious leaders, community based organizations and media representatives. Participants reviewed existing materials and developed new print materials and jingles for project intervention areas in five languages: Hausa, Yoruba, Igbo, Pidgin, and English. Key messages were defined for fistula prevention and treatment, FP, birth preparedness, ANC and skilled birth attendance, and FGM/C. Message development specifically focused on ensuring materials were gender and culturally sensitive and used a rights-based approach. The communication materials, which included jingles, posters, hand bills, flyers, t-shirts, hijabs, and face caps, were pretested and finalized in the fourth quarter.

Town hall meeting with LGA Chairman and Village Heads in Jega, Kebbi State. Credit: FC+/Nigeria

FC+/Nigeria supported a total of 342 community outreach events in Nigeria, reaching over 150,000 people during FY 15/16, see Table NGA1. FC+ efforts supported community based organizations (CBOs), religious leaders and other community structures in Cross River, Ebonyi, Jigawa, Kebbi, Sokoto and Zamfara States. CBOs were supported to build the capacity of community structures like the Ward Development Committees (WDC) and volunteers, as well as to carry out community awareness and sensitization activities reaching people with messages about fistula treatment and prevention, FP, and other maternal health messaging. Religious leaders from Kebbi, Sokoto, and Zamfara States received orientations on maternal health issues, especially fistula related topics, for their religious activities involving the public.

Table NGA1: Community Outreach/Education/Advocacy Events, By Quarter, FY 15/16

Type of Event	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Existing community activity	0	0	58	27,080	113	9,481	25	26,263	**196**	**62,824**
Maternal health/ fistula-focused	146	87,239	0	0	0	0	0	0	**146**	**87,239**
Total	**146**	**87,239**	**58**	**27,080**	**113**	**9,481**	**25**	**26,263**	**342**	**150,063**

Several mass media activities were conducted in the second quarter with the goal of educating and sensitizing the general public on issues related to fistula prevention and treatment, maternal and newborn health risks of prolonged obstructed labor, and other maternal health issues. A number of radio programs were carried out in supported states, including the monthly Health Watch program aired by Radio Nigeria, the largest radio network in the country.[15] Radio programs were also organized to create awareness at the state level using the local languages of Igbo and Hausa. A popular live call-in Radio Link program was also held at the national level, targeted at enlightening and advocating to both policy makers and the general public to play a part in eliminating fistula in the society. This program received over 200 text messages, phone calls and email messages from listeners supporting both governmental and societal action on issues like ending child marriage and female genital mutilation and to eradicate fistula. Wives of the Governors of Ebonyi and Niger States participated in the national and state level programs.

Town Hall Meeting in Zamfara. Credit: FC+ Nigeria

Given low use of preventive maternal health services, including FP, in many of the FC+ focal states in Nigeria, efforts have been made to cultivate champions for social change within communities, with a focus on existing community development structures such as WDCs and other influential social leaders. FC+/Nigeria conducted training of 214 community volunteers and educators not formally affiliated with a health facility, see Table NGA2. Trainees included 34 CBO staff from six supported states who received orientations on maternal and newborn health and the risks of prolonged/obstructed labor, as well as 30 religious leaders from Zamfara, Sokoto, and Kebbi States. 150 community volunteers, including WDC members, were trained in Cross River, Jigawa and Sokoto States.

[15] Overall the Radio Nigeria listening audience is estimated at 1 million, but it is difficult to gather estimates for a particular broadcast, so we are not reporting this number.

Table NGA2: Community Volunteer/Educator Training, Participants by Topic, By Quarter, FY 15/16

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
Religious leaders	0	30	0	0	**30**
CBO staff	0	24	10	0	**34**
WDC/community members	0	0	150	0	**150**
Total	**0**	**54**	**160**	**0**	**214**

Two FC+/Nigeria staff members attended the SBCC Summit and Objective 2 Experts' workshop held in Ethiopia in February 2016.

A program designed and implemented at Kebbi VVF Center by the resident fistula surgeon has positively impacted the marital outcomes of women with fistula at the hospital. Prior to implementation, most women were served divorce papers before undergoing surgery. This surgeon has designed and carried out husband education and community outreach programs that have transformed the role and involvement of husbands in the care of women with fistula. Post-implementation, men are routinely accompanying their wives to facility visits, supporting them during hospitalization and bringing them to the requisite post-op care and FP visits during the six-month period post-fistula surgery. FC+ is looking closely at this program to consider expansion to other sites, as well as potential implementation in other FC+ countries.

Objective 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

FC+/Nigeria worked with the Population Council to carry out formative research related to reduction of financial barriers to accessing fistula care services in Kano and Ebonyi States (see Section II, Objective 3) during FY 15/16. Based on the findings of this research, which were shared with USAID/Nigeria and USAID/Washington, an intervention has been developed that will be tested through follow-up research in Ebonyi and Katsina States, linked with the NOFIC Abakaliki and NOFIC Babbar Ruga. This intervention protocol has been developed and ethical approvals obtained. Baseline data has been collected in the study intervention site (Ikwo LGA) and comparison site (Izze LGA) in Ebonyi State. In the first quarter of FY 16/17, similar data will be collected in intervention and comparison sites in Katsina State. Actual implementation of the pilot interventions is planned for November 2016.

The planned intervention specifically addresses barriers including low awareness, high stigma, high cost of accessing services, and provider "gate-keeping" at lower levels of the health system. The intervention will utilize uniform fistula messages disseminated through multiple communication channels, a simple screening algorithm employed through a hotline, job aides for PHC providers and community agents, and transportation vouchers for suspected cases to access diagnostic and treatment services. The intervention will utilize three key communication channels: mass media messages advertising a fistula screening hotline using interactive voice response (IVR) technology; community outreach by community-based organizations; and PHC workers. The screening hotline, conducted in partnership with VOTO Mobile, will enable

women to be screened as potential fistula cases and provided with direct access to treatment information and referral.

The project has identified a transport organization in Ebonyi, the National Union of Road Transport Workers, as a partner for transportation of fistula clients during the pilot intervention. Transport vouchers will be used by clients, who have been identified and screened, for transport to the fistula treatment center by members of the Union. The study findings will be shared with actors across Nigeria for potential scale-up if there is evidence of increased case finding and access to treatment for women with fistula.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

In addition to the data and monitoring tools described under Objectives 1 and 5, FC+ has worked throughout FY 15/16 to produce a concise client booklet to be used by health facilities for documentation of complete client care, from admission to discharge. The booklet will create uniformity and serve as a source of reliable patient information. The development and review of the booklet has taken place under supervision of the FMOH and SMOH, with a specific eye towards ensuring reportable indicators are included and that the data can be transferred into electronic medical records systems. The booklet will be submitted to the FMOH for final approval in the first quarter of FY 16/17, and the first page of the booklet in included in Appendix S.

Participants at the Providers' Network Meeting in May 2016. Credit: FC+/Nigeria.

The annual Providers' Network Meeting was held in Nigeria in May 2016, providing the opportunity for surgeons, health officials and other relevant health staff to come together to discuss their current challenges, share information and resources, and plan together to strengthen fistula service provision throughout the country. An interactive session between policy makers and service providers was held during this year's meeting, providing an opportunity for advocacy and strengthened collaboration.

As part of project commitments to ensure improved quality and standardization of fistula service delivery, FC+ has, in consultation with relevant stakeholders, reviewed facilitative supervision and monitoring tools to ensure they align with national quality assurance and quality improvement tools. The Nigerian National Primary Health Care Development Agency's Integrated Supportive Supervision (ISS) tool was reviewed, edited, and adopted by FC+.

During the fiscal year, clinical monitoring and supportive supervision visits took place at all supported treatment sites as well as hundreds of prevention-only sites in Bauchi, Ebonyi, Sokoto, Kebbi, Zamfara, Katsina, and Kano States.

FC+ has devoted significant attention and resources toward increasing the number and quality of fistula repairs conducted in Nigeria. As a result, the project has explored expansion to new sites

while leveraging on the existing network of fistula providers, training surgeons, comprehensive resource mobilization, employing a modified pooled effort approach, enhanced client mobilization and upward review of incentives to surgical teams. Throughout all of these approaches, there is a focus on ensuring a high level of clinical quality in a repair services.

As part of these expansion efforts, site assessments were carried out at facilities for potential support in Plateau, Benue and Zaria States. Support to Pope John Paul II Family Life Centre VVF and Maternal Injuries Hospital and Hajiya Gambo Sawaba General Hospital began during this fiscal year. A whole-site orientation to obstetric fistula management was carried out at Pope John Paul II Family Life Centre VVF during the third quarter. Training support to the Plateau site, Evangel VVF Centre in Jos City, began during this year as well; however, no repairs have been supported at this site yet, and the site is not represented in Figures NGA1 and NGA2 below.

Whole site orientation at Pope John Paul II Family Life Centre VVF. Credit: FC+ Nigeria.

As described in Section II, Objective 1, FC+ has been in discussions with Medical Aid Films to develop a short film that will provide an orientation to clinical trackers and tools that will help strengthen clinical quality of fistula repair service provision. Filming is expected to begin during the first quarter of FY 16/17 in Nigeria.

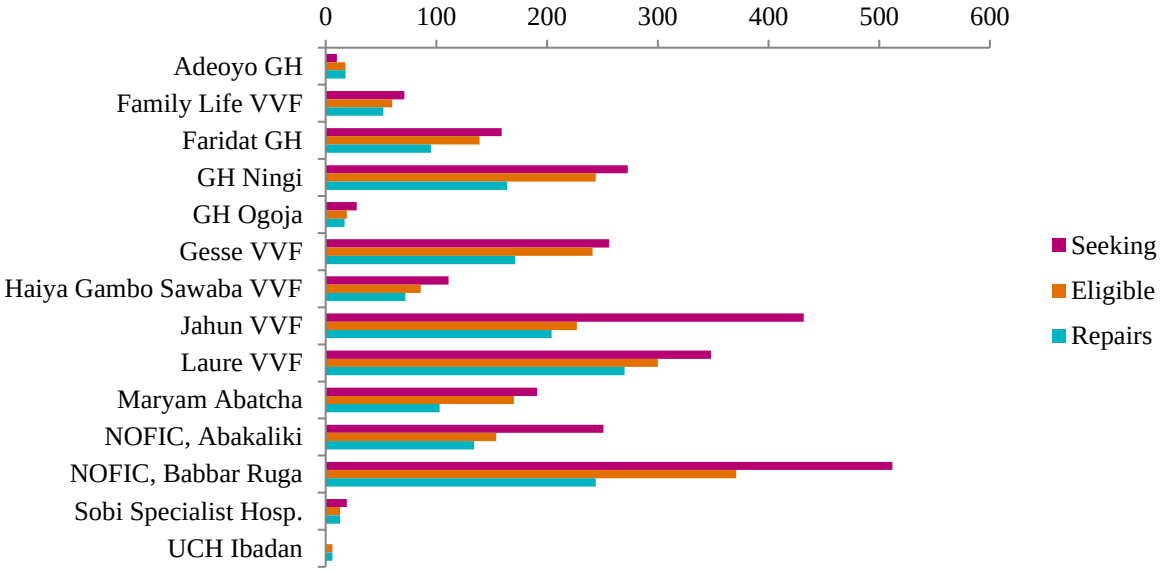
During FY 15/16, 2,661 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 2,296 were diagnosed with fistula (86%). Of those diagnosed with fistula, 2,048 were medically eligible to receive treatment (89%). FC+ supported 1,583 fistula repair surgeries during this period (77%). Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. See Figure NGA1 for data on women seeking and requiring fistula treatment and the number of repairs supported, by country. We are also unable to report the number of women repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

During the FY 15/16, Nigeria entered a serious economic recession which affected federal and state ministry budgets; resulting in high cost of supplies and commodities. FC+ also suspended the provision of pharmaceuticals to supported facilities, to ensure compliance with donor regulations. Given these constraints, the number of supported surgical repairs dropped and the expected targets for the fiscal year were not met.

All supported repair sites in Nigeria offer catheterization for conservative management of obstetric fistula. In addition to those fistula repair surgeries reported above, 261 women received catheter treatment for fistula at eleven supported sites, the majority of which took place at

NOFIC Babbar Ruga (55%). 69% of catheter-treated cases were closed and continent at discharge, and 5% were closed and incontinent. Now that the national guidelines on catheterization have been approved, in the fourth quarter of the fiscal year, FC+ will commence training partners according to those guidelines in FY 16/17.

Figure NGA1: Number of Women Seeking and Eligible for Fistula Treatment, and Number of Surgical Repairs, by Site, FY 15/16



Data on the etiology of diagnosed fistula was available for 271 (12%) cases. Once new standardized records are rolled out in partnership with the FMOH, this data will become more readily available. Of those cases where etiology was identified, the vast majority (73%) were due to prolonged/obstructed labor. 20% were diagnosed as iatrogenic fistula, 2% as traumatic and the remaining cases attributed to cancer and congenital fistula. In Nigeria, the data on iatrogenic fistula diagnosis is sourced from operation notes across supported facilities where the assumption is that all ureteric fistulas are iatrogenic in origin. Because the surgeons are often absent at the time of reporting, it has been difficult to confirm these data. Tools such as the revised fistula registers and the Surgical Safety Toolkit will improve the availability of fistula etiology data.

The 1,583 fistula repair surgeries supported during FY 15/16 were conducted at 14 FC+ supported hospitals and through partnership in one pooled effort with the Islamic Medical Association of Nigeria in Niger State, see Table NGA3 for detail by quarter. FC+/Nigeria supported a combination of routine services and pooled efforts at supported sites to both eliminate the backlog of fistula cases and provide ongoing services. It has become clear that some sites are reluctant to establish routine services and prefer to only employ the pooled effort model, which does not strengthen routine service provision of fistula services. Therefore, efforts have been made to emphasize the importance of routine, high quality service provision, and the project has scaled down its support for the pooled effort approach. One potential strategy involves training a resident doctor in such centers to handle simple cases on a routine basis. The

resident doctor would be supported by a visiting senior surgeon on a regular basis who could repair more complicated cases while building capacity for the resident doctor. Pooled repairs accounted for 749 surgical fistula repairs during FY 15/16, representing 47% of all surgical repairs. This was the first year of USAID-supported fistula activity in Nigeria in which routine repairs accounted for the majority (53%) of surgical repairs.

A new collaboration in FY 15/16 involved a jointly organized and conducted pooled fistula repair effort at Umaru Musa Yar'Adua Memorial Hospital, Sabon Wuse, Niger State in collaboration with the Islamic Medical Association of Nigeria (IMAN) during the third quarter of FY 15/16. IMAN is a faith-based, non-governmental, non-political organization made up of qualified health care professionals. The Association had requested FC+ project support for planned pooled efforts and FC+ provided surgeons for this activity, during which 20 repairs were completed. This collaboration will continue in FY 16/17 and may expand to additional states in Northeast Nigeria.

Table NGA3: USAID-Supported Surgical Fistula Repairs, by Site, By Quarter, FY 15/16

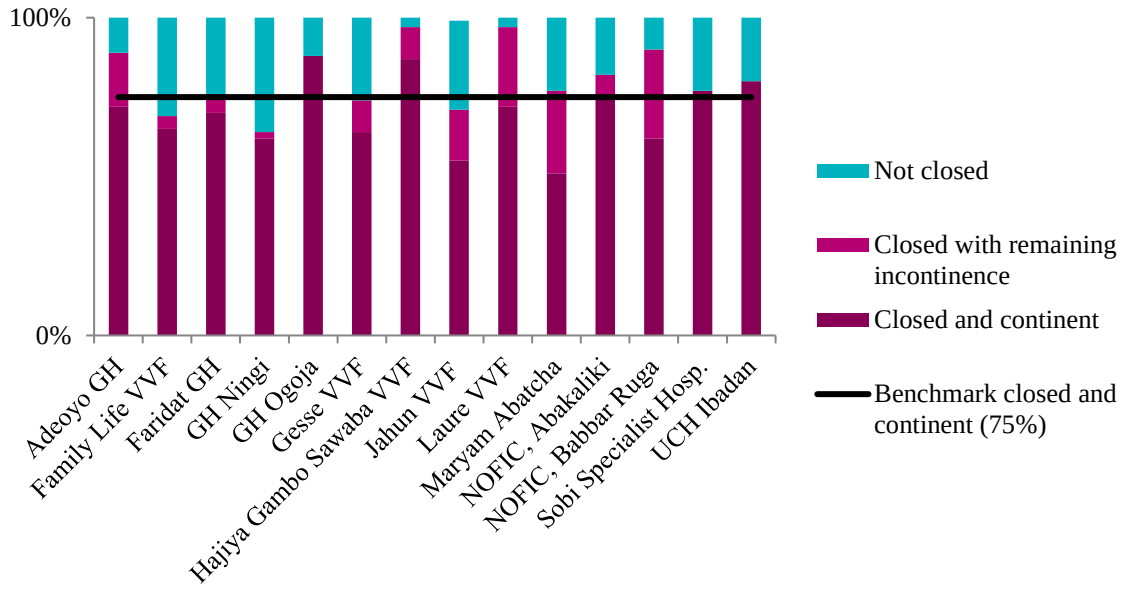
Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Adeoyo General Hospital, Ibadan	8	10	0	0	**18**
Family Life VVF Center	NS	NS	24	28	**52**
Faridat General Hospital, Gusau	44	25	23	3	**164**
General Hospital, Ningi	32	66	34	32	**164**
General Hospital, Ogoja	7	0	10	0	**17**
Gesse VVF Center, Birnin Kebbi	54	28	53	36	**171**
Hajiya Gambo Sawaba VVF Center	NS	NS	58	14	**72**
Jahun VVF Center, Jigawa	NS	64	72	68	**204**
Laure VVF Center	72	110	55	33	**270**
Maryam Abatcha Women and Children's Hospital, Sokoto	20	33	34	16	**103**
NOFIC, Abakaliki	39	39	56	0	**134**
NOFIC, Babbar Ruga, Katsina	68	53	68	55	**244**
Sobi Specialist Hospital, Ilorin	13	0	0	0	**13**
University College Hospital, Ibadan	6	0	0	0	**6**
IMAN pooled repair effort, Niger State	0	0	0	20	**20**
Evangel VVF Centre, Jos, Plateau State	0	0	0	0	**0**
Total	**363**	**428**	**487**	**305**	**1,583**

Data on the number of simple vs. not simple repairs discharged during the quarter has been challenging to obtain, for reasons similar to those reported above regarding etiology. Roll out of the revised fistula registers developed together with the FMOH is intended to allow for more complete data on the clinical profile of all fistula patients in the future.

Of all fistula repair surgeries discharged during FY 15/16, 81% were closed at discharge: 65.4% were closed and continent and 15.4% were closed and incontinent. Those cases that were not closed at discharge (19%) are primarily women who have undergone multiple previous repairs. These outcomes reflect an improvement over the previous fiscal year (74% closed at discharge), following intensive monitoring and feedback by FC+/Nigeria at supported sites. It is hoped that the ongoing efforts to ratify a national policy on WDI will help to ensure that those women who

remain not closed receive appropriate treatment and support. Outcomes for discharged patients are presented, by site, in Figure NGA2. Clinical and program staff have designed a tool for follow up with relevant sites to gain clarity on the causes of low closed rates, and what steps, if any, are necessary to address the issue.

Figure NGA2. Outcome Rates for Surgical Repairs, by Site, FY 15/16



Reported complications were low at supported sites (3.7% overall) with a range of 0% (GH Adeoyo, Hajiya Gambo Sawaba, Laure VVF Center, Maryam Abatcha and UCH Ibadan) to 18% (GH Ogoja).[16]

FC+/Nigeria trained a surgical team from NOFIC Ningi in Bauchi State over the course of the second and third quarters, and in the fourth quarter, a surgical team from Gesse VVF Center in Birnin Kebbi in fistula surgical repair (see Table NGA/4). A total of seven surgeons were trained during FY 15/16: four received their first training in fistula surgical repair and three participated in continuing training.

Table NGA4: Surgical Fistula Repair Training, Participants by Trainee Institution, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	1st	Cont	1st	Cont	1st	Cont	1st	Cont	1st	Cont
GH Ningi	0	0	3	0	3	0	0	0	3[17]	0
Gesse VVF Center	0	0	0	0	0	0	1	3	1	3
Total	**0**	**0**	**3**	**0**	**3**	**0**	**1**	**3**	**4**	**3**

[16] GH Ogoja had seven discharged repairs in the first quarter, of which three experienced anesthesia related complications.

[17] The same three surgeons were trained in the second and third quarters at GH Ningi.

To strengthen the capacity of supported fistula centers and healthcare providers in clinical safety for the clients before, during and immediately after anesthesia and fistula/POP repairs, FC+/Nigeria trained surgeons, theater nurses, and nurse anesthetists in the management of anesthetic complications during the second and third quarters. A total of 31 participants were trained from fistula centers in Sokoto, Kebbi, Zamfara, Bauchi, Jigawa, Kano, Katsina, and Plateau States (see Table NGA5). This training was prioritized due to observed poor preparedness of these fistula facilities to manage complications related to anesthesia. FC+/Nigeria also plans to procure basic anesthesia equipment for the management of these complications at the facilities.

As part of fistula prevention efforts, FC+/Nigeria provided training to 533 health care providers during the fiscal year, see Table NGA5. Trainings covered topics including FP methods and counseling, infection prevention, pre- and post-operative care, anesthesia and facilitative supervision.

Table NGA5: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
FP counseling	170	0	0	0	**170**
FP methods	0	50	0	22	**72**
Anesthesia (pre- and post-operative care)	0	9	21	0	**30**
Pre- and post-operative care	0	0	16	26	**42**
Fistula orientation (whole site)	0	0	47	0	**47**
FP facilitative supervision	0	0	23	35	**58**
Infection prevention	0	0	18	13	**31**
Data management/ DDM	0	0	20	63	**83**
Total	**170**	**59**	**145**	**159**	**533**

In addition to the FP trainings described in Table NGA5, FC+/Nigeria convened a two-day meeting of LGA and State FP Coordinators in Bauchi during the third quarter to review FP activities in each LGA and address issues related to commodities, data management and quality of care, ensure quality of care. Action plans were developed for regular facilitative supervision. Following this meeting, whole site orientations were carried out in three clusters across the 20 LGAs in the state to increase awareness and improve the knowledge and skills of health facility workers, both clinical and non-clinical, on the importance of a client-centered approach for FP services.

During FY 15/16, over 307,000 counseling sessions took place at supported sites in eleven States, and 137,667 CYP were provided, see Table NGA6 for detail, by state. 198,614 of these counseling sessions and 89,341 of these CYP were reported from former T-SHIP sites in Bauchi and Sokoto that FC+/Nigeria was requested to support in reporting during the interim period before the next project is awarded. The method mix for FC+ supported sites (non-TSHIP) contributing to this CYP includes implants (54%), injectables (20%), Copper T IUD (12%), oral pills (4%), and male and female condoms (4%). For the former TSHIP sites, method mix

contributing to this total CYP included: implants (50%), injectables (23%), natural family planning (14%); oral pills (7%); and IUD (3%),

Table NGA6: Family Planning Counseling Sessions and CYP, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP[18]
Bauchi	248	24	0	0	0	0	0	0	**248**	**24**
Cross River	857	1,215	733	1,088	726	1,088	707	1,357	**3,023**	**4,747**
Ebonyi	11,909	3,066	10,007	3,315	12,429	3,639	16,985	5,851	**51,330**	**15,871**
Jigawa	5,790	1,190	5,836	1,328	5,831	1,314	6,101	1,132	**23,558**	**4,965**
Kano	2,212	1,471	3,115	2,002	2,374	1,343	2,535	1,576	**10,236**	**6,392**
Katsina	37	5	46	6	18	2	47	41	**148**	**53**
Kebbi	998	848	1,280	995	1,247	812	1,186	653	**4,711**	**3,308**
Kwara	NS	NS	NS	NS	2,510	2,172	n/a	n/a	**2,510**	**2,172**
Oyo	7,427	6,981	n/a	n/a	n/a	n/a	n/a	n/a	**7,427**	**6,981**
Sokoto	769	524	1,072	891	0	0	921	635	**2,762**	**2,050**
Zamfara	690	517	720	513	750	379	644	353	**2,804**	**1,762**
Former TSHIP Bauchi	23,430	11,915	22,275	9,403	27,866	8,979	27,196	10,420	**100,767**	**40,716**
Former TSHIP Sokoto	29,307	15,675	23,344	10,735	24,054	10,256	21,142	11,989	**97,847**	**48,625**
Total	**83,674**	**43,430**	**68,428**	**30,276**	**77,805**	**29,954**	**77,464**	**34,007**	**307,371**	**137,667**

During FY 15/16, FC+/Nigeria conducted assessments to determine the strength and weakness of obstetric care in selected health facilities. These assessments looked at the availability, utilization, and challenges in the provision of quality essential and emergency obstetric services, including the use of partograph and C-section. Due to pending staff training, supported sites providing obstetric services have not yet begun to report data on deliveries to the project. Partograph review was carried out during the first quarter which provides baseline data on many aspects of labor and delivery care for several facilities where FC+/Nigeria may provide inputs.

Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

During the first half of the fiscal year, FC+/Nigeria continued discussion and follow up meetings with the fistula desk office and DPRS (Department of Planning Research and Statistics) of the FMOH towards final approval for the adoption of revised fistula registers as national tools for fistula data collection and management at all fistula centers in Nigeria. The registers were approved nationally for inclusion into the national health data platform and were piloted in the

[18] Due to rounding, totals may differ slightly from the sum of individual quarters.

second half of FY 15/16. Training on the new registers for staff from selected supported health facilities in Ebonyi, Kano and Jigawa States (see Table NGA5) was provided in May 2016 in collaboration with the FMOH Fistula Desk Office and the Department of Planning Research and Statistics. The use of the registers was then assessed jointly by FC+, FMOH and State MoH staff during quarterly monitoring visits at NOFIC Abakaliki, Jahun General Hospital and Laure VVF Centre. Findings indicated that the registers were being successfully implemented at the sites. Scale-up of the national registers will take place after final approval from the FMOH.

FC+ successfully advocated for the inclusion of 23 fistula indicators (see Appendix R) in the National Health Management Information System (NHMIS), a significant increase over the previous six indicators. It is expected that this effort will ensure ownership and sustainability in the system.

FMOH and FC+ team during assessment visit for new fistula management tools. Credit: FC+/Nigeria

Throughout FY 15/16, FC+/Nigeria carried out data verification and validation meetings at supported sites in Nigeria. Data were verified using two different approaches: direct visits to facilities with hands on review of site registers and/or organized regional data verification meetings with HMIS Officers and FP Coordinators who bring their registers to the meetings. Each approach has advantages: the former is most productive with opportunities to directly correct errors and interface with service providers while the latter is more cost- and time-efficient. The data verification process provided opportunities for all supported sites currently providing treatment and prevention services to have internal data reviews whereby program data was analyzed, issues identified, and action plans developed. Quarterly internal data for decision making (DDM) meetings are conducted within FC+/Nigeria to routinely monitor and discuss clinical and programmatic data, and DDM training was also incorporated into the community engagement partner trainings described under Objective 2. Two FC+/Nigeria staff attended the EngenderHealth CDDM meeting in Addis Ababa in June 2016.

The large number of prevention-only sites that the project supports, and is required to report on (including the former TSHIP facilities) necessitated employing data entry consultants to help with documentation, validation, collection, and collation of FP data in four states: Sokoto, Bauchi, Ebonyi, and Jigawa. These consultants also helped in the distribution of FC+ FP summary form booklets to 736 supported health facilities during the fiscal year.

The FMOH in Nigeria has expressed great interest in the use of an electronic medical records system (EMRS) for tracking indicator data from clinical care, for standardization of documentation and for strengthening emerging platforms for safe surgery, anesthesia and obstetrics care. This is also an area of strong interest for the FC+ project and staff have

commenced exploration for a secure, easy to manage, and highly affordable software for this purpose. Preliminary discussions took place during the first half of the fiscal year between FC+/Nigeria, FC+/Global, and an in-country EMRS expert with OpenMRS emerging as the leading software contender. In the fourth quarter four health facilities (Evangel VVF Centre, NOFIC Babbar Ruga, NOFIC Abakaliki, and Gesse VVF Centre) were assessed as possible pilot locations for EMRS. Assessment criteria included the availability of reliable power supply, office space, computers, human resources, and management willingness to implement an EMRS as well as any previous EMRS efforts. This data is currently being analyzed and a pilot location will be selected in the first quarter of FY 16/17.

During the second quarter, USAID/Nigeria conducted a Data Quality Assurance (DQA) exercise in two states supported by FC+: Ebonyi and Cross River. FC+ clinical and community indicators were assessed in terms of validity, reliability, timeliness, precision, and integrity and the system that generates these data was explored. Findings from this exercise were disseminated at a debriefing meeting in March 2016; shortfalls in data precision are expected to be addressed through implementation of the newly approved national fistula register tools.

During FY 15/16, all supported treatment sites were able to meet at least once to review data and utilize it for planning and decision-making as the FC+/Nigeria data officer visited sites quarterly and facilitated data collection and review. All sites providing surgical fistula repairs with FC+ support met every quarter, with the exception of the two newest sites (Family Life Center and Hajiya Gambo Sawaba) since they did not begin receiving support until the third and fourth quarters.

Four health facilities also held formal DDM meetings during the fiscal year (Maryam Abacha, Gesse VVF Centre, FaridatGH, and NOFIC Babbar Ruga). This activity sparked discussions within the facilities around success and challenges, and helped staff chart a course to improve quality of care in their facilities. Action plans were articulated, with specific tasks allocated to point people with supervision from the medical director of each health facility. One example of these DDMs leading to positive impact is from Gesse VVF Center in Kebbi State, where the data review illustrated a low closure rate for surgical fistula repairs at discharge. The staff identified areas they felt needed improvement and the FC+/Nigeria clinical team provided clinical support. By the end of the fourth quarter, the facility showed significant improvement in closure rates.

Additional Objective: Sexual and gender-based violence – Addressing the needs of the girls abducted in Chibok, Nigeria

During FY 15/16, FC+/Nigeria established contact with the newly created "Special Duties Unit" of the FMOH established to coordinate all health and humanitarian response for internally displaced people (IDPs), due to the insurgency in the Northeast. The unit is not yet fully active, with the originally appointed director leaving the post suddenly and an interim director currently in place. The Special Duties Unit has developed a comprehensive strategy in collaboration with the National Emergency Management Agency (NEMA). The strategy document "Northeast

Health Sector Humanitarian Crisis Response 2016 - 2017" goes beyond addressing the needs of survivors of SGBV; it is a holistic plan that involves health systems strengthening, management of public health emergencies, as well as sexual and reproductive health. The strategy was launched by the Hon. Minister for Health, together with a technical working group for effective coordination and implementation. FC+ is a member of this working group.

During the fiscal year, the FC+/Global Gender Focal Point and the EH Senior Associate for Gender conducted a workshop for FC+/Nigeria staff on gender norms, equality, power, and their effects on access to services. Gender mainstreaming was introduced and encouraged across all project related activities. In addition, a Gender Working Group was established at the country level for both internal needs as well as to facilitate gender mainstreaming, including into trainings and with SGBV-related interventions. Activities have been planned for FY 16/17, including assessment of SGBV and fistula in IDP camps and training of the National Working Group Members on the algorithm and toolkit for management of survivors of SGBV in Nigeria. The Project will implement these activities in close collaboration with the Special Duties Unit of FMOH.

Uganda

USAID-supported fistula services in Uganda began in 2004 through the previous FC project and continue through FC+ in four treatment and prevention sites and 14 prevention-only sites as of September 30, 2016.

In Uganda, FC+ supports fistula repair services, clinical training, efforts to improve the quality of obstetric care and FP services, and building community awareness. The project is increasing emphasis on the integration of FP services with fistula and maternal health care and piloting efforts to meet the reintegration needs of women who have undergone fistula repair.

Delayed approval of the FY 15/16 budget slowed the implementation of PRH-supported activities. The FC+/Uganda M & E Program Associate left the project during the second quarter, with two new members coming on board since. The Kampala office is shared with the Bill and Melinda Gates Foundation (BMGF)-funded project, ExpandFP.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

FC+ Uganda works to strengthen the enabling environment for fistula services through cultivation of partnerships with governmental and non-governmental agencies, participation in technical working groups and professional meetings and conferences, and by convening relevant stakeholders in Uganda through partner meetings and updates.

In the fourth quarter of FY 15/16, FC+ Uganda organized a two-day partners' review meeting for 65 participants from FC+ implementing partners. These included representatives from the MoH, including the Commissioner of Clinical Services and leaders from various district health offices. The FC+ Project Director was able to take part, along with FC+ Uganda staff. The purpose of the meeting was to discuss programmatic progress thus far in the FC+ project and to share achievements, best practices, and lessons learnt from the various stakeholders. The meeting included presentations from various health officials at the national, district and health facility levels. Highlights from the meeting included:

- Agreement among participants to clear the current backlog of fistula patients, with a consensus that all regional referral hospitals should conduct routine repairs in addition to pooled efforts.
- POP services should be provided routinely rather during concentrated fistula repair efforts.
- FC+ will work with the MoH to revise the current fistula strategy, which should include newly developed client trackers.
- Partners should consider available opportunities, such as working with Direct Relief to address potential stockouts of drugs or other supply issues that may arise.

At the end of FY 15/16, Kitovu Mission Hospital successfully received their first shipment of two Fistula Modules from Direct Relief. This was the culmination of an application submitted by hospital administration, with facilitation from FC+.

During the first quarter of FY 15/16, FC+/Uganda took part in the inaugural Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Assembly organized by the Ministry of Health. The Assembly brought together key donors, implementing partners (IPs) and UN agencies to discuss the progress made so far by the country towards ending preventable child and maternal deaths and rolling out of the Ministry of Health (MOH) Sharpened Plan.[19] It was also an opportunity to take stock of the progress made by different IPs in delivering their respective mandates, and identify where the outstanding need lies in terms of coverage and financing gaps. The FC+/Uganda Country Director made a presentation about the interventions being implemented in Uganda, the financial resources invested in the last three years, key outputs/achievements, challenges and lessons learnt so far. Other presenters included WHO, UNFPA, UNICEF, USAID, World Bank, Belgian Technical Corporation, SIDA, MSI, CHAI, AMREF, Save the Children, PSI, World Vision, and Inter Religious Council of Uganda. Discussions covered how to leverage available resources to address the five strategic shifts as laid out in the Sharpened Plan. Similar assemblies will be organized annually by the MOH to promote mutual accountability and learning among the key donors and implementing partners in the RMNCAH field.

Also during the first quarter, FC+/Uganda participated in the Global Financing Facility (GFF) country consultation meeting organized by the World Bank, in collaboration with the MOH. The meeting, held in October 2015, brought together different IPs and UN agencies including WHO, UNFPA, and UNICEF to provide input into the Investment Case and Health Financing and Investment Strategy that the MOH is developing. Once the strategy is complete, it will provide a comprehensive picture of the country's immediate and long term RMNCAH resource needs and will outline strategies to mobilize the requisite domestic (public and private) and international (bilateral and multilateral) funding over time. The goal is to harmonize funding for RMNCAH plans through a common country financing framework which is linked to clear results and backed by common accountability and reporting mechanisms. The World Bank team informed the meeting that USD 40M was already committed through the GFF to fund RMNCAH interventions in Uganda under the "Every Woman, Every Child" initiative.

FC+/Uganda took part in the Uganda Commitments Initiative (UCI) meeting, organized by the MOH in collaboration with Partners in Population and Development. UCI is a country-driven approach which aims at accelerating progress towards RH commodity security by taking a limited number of fundamental RH supplies-related commitments as the entry point for targeted joint technical action at the country level. The goal of UCI is to support the Government of Uganda and national partners to accelerate progress towards achieving Uganda's RH supplies-related commitments. Among the commitments reported as achieved were tax exemption of FP

[19] The Plan envisions five strategic shifts: focusing geographically on areas with the highest number of child and maternal deaths; increasing access of health services to deprived and vulnerable populations; emphasizing high impact interventions that target the direct causes of death; addressing the broader educational, economic and environmental context; and strengthening mutual accountability.
https://www.usaid.gov/sites/default/files/documents/1860/Reproductive_Maternal_Newborn_and_Child_Health_Sharpened_Plan_for_Uganda-Final_Version_Nov2013.pdf

commodities, procurement and distribution of RH supplies to health facilities, operationalizing an RH sub account, allocation of USD 5M by Government for FP supplies and an equivalent amount mobilized from donors. Some of the key commitments not yet achieved included revision of the pre-service training curriculum, recruitment of skilled health workers for hard to reach areas, and putting in place of an RH voucher system for both the public and private sector among others.

During the third quarter, FC+/Uganda participated in District Planning Technical Committee meetings in Kasese and Kamuli Districts, and a joint supervisory tour for all USAID-funded implementing partners in Kasese district. One of the projects visited was Karambi HC III where FC+ is championing the promotion of maternal health through clinical (IP, FP, and partograph) and community approaches (SWT and VHT interventions).

The FC+/Uganda Country Manager and the Global Project Director participated in a Board Meeting of the College of Surgeons of East, Central and Southern Africa (COSECSA) Annual General Meeting and Scientific Conference in Blantyre, Malawi. In addition to scientific sharing, a graduation ceremony was held for post-graduate fellows across a wide range of surgical disciplines that included pediatric surgery, anesthesia, orthopedic, plastic, and general surgery. It was at this conference that 'a golden' opportunity of East, Central and Southern Association of Obstetricians and Gynecologists (ECSAOGS) joining the global surgical community of practice was realized. FC+ continues to support ECSAOGS in a bid to ensure that fellowships for Obstetricians and Gynecologists start and are embraced in COSECSA post graduate fellowships. This initiative is being implemented with the support of the COSECSA Secretary General and G4 Alliance Vice Chairperson, as well as the President of the West African College of Surgeons.

At the end of the second quarter, FC+/Uganda took part in a workshop to finalize the MOH FP basic skills curriculum in Kampala, Uganda, 22 – 23 March 2016. This workshop was a follow on to the action plans made by the Uganda team, led by the MOH, during the global conference on accelerating access to post-partum FP in Chang-Mai, Thailand (June 2015). One of the key strategies was to improve knowledge and skills of health providers by reviewing MOH FP Basic clinical skills training curriculum. This workshop was the third stakeholder's meeting to review the MOH FP Basic skills curriculum. The workshop was attended by participants from MOH, MSIU, PACE, RHU, WHO, UCMB, UPMB, AOGU, Mulago Hospital, and Jhpiego.

FC+/Uganda cultivated partnerships aimed at reaching underserved groups. FC+/Uganda partnered with StrongMinds Uganda, an NGO working with treating depression among women, to train the health care workers involved in interacting with obstetric fistula clients from the current and planned treatment sites of Jinja, Kamuli, Kitovu, and Hoima Hospitals in depression screening. Screening for depression is going to be done to assess the magnitude of depression among the fistula clients so that FC+/Uganda can use this evidence to establish a mental health care package to address this need.

FC+/Uganda requested from the Ministry of Education a formal collaborative partnership to support adolescent/youth reproductive health programming. Under this partnership, the Ministry

of Education will identify a technical focal person to identify schools for collaboration in implementing this programming for school-aged youth.

FC+/Uganda commemorated the International Day to End Obstetric Fistula (IDEOF) on May 23, 2016 in Arua District, located in northwest Uganda (see Appendix U for a full summary of all FC+ IDEOF activity). The day's theme was, "End fistula within a generation: Create awareness now." Prior to the commemoration, there was a concentrated fistula screening and repair effort supported by AMREF, for which FC+/Uganda supported the activities of three fistula surgeons. Celebrations included a march through Arua town and presentations by local and national officials including the current Minister of State for Health. Presentations advocated for creation of and support for fistula related services, as well as avoiding early marriage, male involvement, and the importance of village health teams and local religious leaders in working towards improving health.

During FY 15/16, cost share opportunities were realized through partners providing venues for capacity building trainings, workshops, and meetings among other forms of support for project activities. UNFPA has contributed an operating bed as well as fistula kits to Kamuli Hospital, increasing their capacity to provide services.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+/Uganda is embarking on implementation of a youth component as part of its community engagement portfolio. As part of efforts to build on the expertise of other stakeholders in this area, discussions and a site visit were initiated with the Private Education Development Network (PEDN), an NGO that has been implementing youth-focused activities. FC+ plans to partner with PEDN to leverage their skills to address youth social and financial education in partnership with FC+'s efforts to address sexual and reproductive health.

A MOU has been developed and during the fourth quarter ten schools in Jinja and Kamuli were mapped to identify where the youth strategy will be implemented. The mapping involved identifying the geographical locations of the schools and assessment of teachers' knowledge, confidence, and comfort levels in facilitating sexual reproductive health sessions to their students. Eight focus group discussions were conducted in the schools to establish the information needs of students which will then guide the drafting of the curriculum.

Following this mapping exercise, a meeting was held with the school health department in order to harmonize the content of the strategy and ensure it is aligned with the current policy guidelines for in-school youth in Uganda. Trainings were then held for teachers and nurses, facilitated by PEDN leaders, to continue introducing the concepts of adolescent sexual and reproductive health and the particular needs and effective approaches in reaching youth. Participants made the commitment to share what they had learned with both their fellow teachers and nurses, as well as

their students. FC+/Uganda will explore an expansion to out-of-school youth clubs during year four.

As part of efforts to increase public awareness of fistula prevention and treatment, FC+/Uganda carried out over 2,000 in-person community outreach/education/advocacy events reaching 108,312 participants during FY 15/16, see Table UGA1. Mass media efforts reached an estimated 5,031,400 people. In-person community outreach has primarily worked with village health teams (VHTs) and local religious leaders to increase awareness and health-seeking behaviors among more rural communities, while mass media has utilized radio programs as a means of connecting with broader audiences, particularly in harder to reach areas.

Throughout the fiscal year, FC+/Uganda continued holding quarterly meetings with village health teams (VHTs) at Buraru and Buseruka health facilities, reviewing maternal and FP service data and progress made to date in mobilizing communities in the health facility catchment areas as well as providing technical support to address challenges within their work.

In an attempt to increase access and utilization of maternal health and FP services in hard to reach areas within the catchment areas of Buraru and Buseruka HC IIIs, FC+/Uganda also worked with other health workers at the two facilities to conduct community outreaches. FC+/Uganda will leverage resources by working closely with ExpandFP in community engagement efforts. In the third and fourth quarter, FC+ Uganda conducted a training in "Promoting Maternal Health and Preventing Obstetric Fistula" for VHTs (see Table UGA3) to increase their participation and help them work together for more effective outreach.

VHTs conducted awareness raising activities, including household visits and broader community sensitization events throughout the fiscal year, covering topics including FP, male involvement, birth preparedness, and utilization of ANC and maternity services.

Religious leaders of Bunyoro Kitara Diocese in Hoima district reached nearly 8,000 people during FY 15/16 with messages on fistula treatment and prevention as well as promoting antenatal care services in the different churches that they manage. Christian and Muslim leaders in Masaka reached over 44,000 community members with similar messages.

During the third quarter of FY 15/16, FC+ Uganda worked with staff at Lukolo HCIII to conduct a Site Walk Through (SWT), which was attended by 55 community representatives including local council members, health management staff and local VHTs. The goal was to increase awareness of the services provided at the facility, information which

Site Walk Through at Lukolo HCIII in Jinja. Credit: FC+ Uganda

could then be shared with the broader community. Attendees made individual commitments towards addressing salient barriers to service utilization identified by the community members.

In addition, FC+/Uganda held meetings with the community outreach team at Kitovu Mission Hospital to establish messages being used to promote maternal health and obstetric fistula prevention in the community and also streamline the mode of reporting of community based interventions back to FC+/Uganda.

In addition to the IDEOF activities described under Objective 1, commemorations were held during the third quarter at Kamuli Hospital, which launched provision of fistula treatment services in April 2016. Politicians and health workers from the district attended a launch event that helped raise awareness of fistula and drew media attention to available services.

During the fourth quarter, 61 elected officials from Jinja and Kamuli districts participated in efforts to sensitize them in their role towards preventing fistula and mobilizing fistula clients for care and support.

Five radio talk shows were conducted in Jinja, Kamuli, and Masaka reaching over an estimated 5,000,000 listeners, covering both broader sexual and reproductive health issues and services, and fistula and POP services in particular. Four of the five broadcasts were timed to help mobilize area clients for a concentrated repair effort at the hospitals.

Table UGA1: Community Outreach/Education/Advocacy Events, By Quarter, FY 15/16

Type of Event	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Existing community activity	6	34,539	2	14,635	465	12,435	1,550	37,154	**2,023**	**98,763**
Health facility	0	0	0	0	1	55	0	0	**1**	**55**
Policy makers	0	0	0	0	0	0	2	61	**2**	**61**
Health providers	0	0	0	0	1	103	1	507	**2**	**610**
Maternal health/ fistula-focused	0	0	0	0	0	0	1	6,823	**1**	**6,823**
Radio/TV	0	0	1	645,395	1	724,599	3	3,661,406	**5**	**5,031,400**
Total	**6**	**34,539**	**3**	**660,030**	**468**	**737,192**	**1,557**	**3,705,951**	**2,034**	**5,137,712**

FC+/Uganda did not carry out any community volunteer/educator training during FY 15/16.

FC+/Uganda participated in the SBCC Summit held in February 2016 at the United Nations Economic Centre headquarters in Addis Ababa, Ethiopia. FC+/Uganda was represented by several community engagement and SBCC technical staff. One staff participated in the Objective 2 Experts' workshop.

FC+/Uganda joined the rest of the world in commemorating the 16 Days of Activism against Gender-Based Violence, November – December 2015. The campaign was meant to raise public awareness and mobilize communities to end violence against women. FC+/Uganda had a booth at the national launch event in Amuria district in Eastern Uganda. Over 200 participants

including Government and UN officials visited the booth where they were told about FC+ and EngenderHealth work in Uganda and globally. They also received brochures and T-shirts branded with FP and maternal and reproductive health messages.

Obj. 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

FC+/Uganda worked with the Population Council to conduct formative research on barriers to fistula treatment during FY 15/16. Ethical approval from the Uganda National Council for Science and Technology and the President`s Office was secured during the first quarter of FY 15/16. This was followed by training of research assistants, data collection that lasted one month at Kitovu and Hoima Hospitals and data transcription. Population Council completed data analysis and a draft report was shared with USAID Uganda for review in the second quarter.

Based on the findings of this research, an intervention package has been designed to address the barriers that were identified in the initial study, specifically low awareness, high stigma, high cost of accessing services, and provider "gate-keeping" at lower levels of the health system. The intervention is being piloted in Kalungu District and offers treatment services to women at Kitovu Mission Hospital in the neighboring Masaka District. The intervention utilizes one tool for fistula screening, a transportation voucher to enable positively screened women to travel to and from the fistula treatment facility for free, and multiple communication channels for fistula messaging, screening and referral. Primary health care providers will be trained to identify potential fistula clients for referral and to facilitate free transportation to appropriate treatment facilities. At the community level, village health team (VHT) volunteers will circulate targeted messages about fistula symptoms and available treatment services; and a free hotline service, which will be widely advertised by VHTs, radio messages, and through flyers, will screen women for fistula via their mobile device using interactive voice response technology. The screening hotline, conducted in partnership with VOTO Mobile, will enable women to be screened as potential fistula cases and provided with direct access to treatment information and referral. Positively screened women identified through each of the channels will receive a voucher for free transportation to and from the fistula treatment facility as well as case-management support from either the community agent or primary health care provider. The project has identified a taxi company in Kalungu District, as a partner for transportation of fistula clients during the pilot intervention.

The Population Council will conduct an implementation research study to evaluate the effectiveness of this intervention package. IRB submission and tool development took place in the third and fourth quarters of FY 15/16. Research assistants have been recruited and training is expected to take place in October 2016. IRB approval is expected in the first quarter of FY 16/17, after which the study will commence.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

FC+/Uganda currently supports four fistula treatment sites in Uganda: Kitovu and Kamuli Mission Hospitals and Hoima and Jinja Regional Referral Hospitals. FC+ support to Kamuli and Jinja began in the third quarter of the fiscal year, with both facilities launching provision of fistula treatment services through concentrated screening and repair efforts. Kagando Hospital is currently supported for prevention-only services, but its treatment capacity is being monitored on an on-going basis with the potential to begin support for fistula treatment in the future.

During the first quarter of FY 15/16, a situational analysis was carried out at four FC+ supported sites (Kitovu, Kamuli, Jinja, and Hoima) to establish the current status of surgical equipment available and ascertain future needs for each site. A WHO-validated tool for assessing emergency and essential surgical care was used, covering infrastructure, human resources, surgical interventions, and supplies. This was supplemented with an EngenderHealth tool that captured data on the availability and state of surgical equipment in the theatre, labor, fistula, and gynecology wards. Some of the equipment assessed included delivery, IUD, and implant insertion/removal, and fistula repair and vasectomy kits. The data collected is currently being analyzed and will be used by to determine the needs of each site and how to address them.

Launch of fistula treatment services at Kamuli Mission Hospital. Credit: FC+ Uganda.

Clinical monitoring visits were carried out at Hoima, Kagando, Kitovu, Jinja, and Kamuli Hospitals during the fourth quarter. FC+ clinical staff met with staff at all sites and facilitated discussions on cross cutting issues of care including: environmental safety mitigation; purchasing, storage and supply management of pharmaceuticals; laboratory waste management; infection prevention; obstetric care; fistula care prevention and care; and FP. Some of the most notable action points to come out of the monitoring visits included:

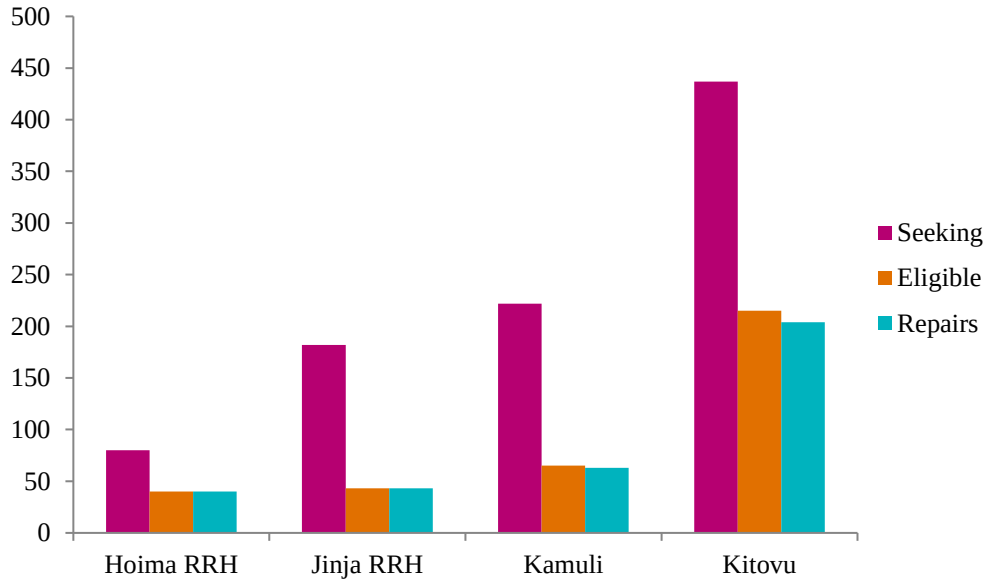
- Institutionalize use of WHO-based FC+ toolkit of surgical safety checklists and trackers if the available records are not able to capture all required information (Hoima);
- Reestablishment of routine fistula repair and care for POP clients (Kagando);
- Review and update staff in EmONC response and management and use maternity data, including C-section rates, for regular review for decision making (Kitovu);
- Ensure that all clients files, including surgical and sentinel events checklists and trackers, are fully and correctly completed (Kamuli); and

- Establish and ensure consistent availability of emergency supplies, including all drugs, IV fluids and sutures for maternity and theater (Jinja).

During FY 15/16, 921 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites, of which 421 were diagnosed with fistula and required treatment (46%). Of those women diagnosed, 364 were medically eligible for fistula surgical repairs (86%). FC+ supported 350 fistula repair surgeries during the fiscal year (96% of those requiring surgery).

Some women may be diagnosed with fistula in one quarter and repaired in the next. Because FC+ does not track individual women through our monitoring and evaluation data collection, we are unable to present a definitive percentage of women requiring repair who receive it. See Figure UGA1 for data on women seeking and requiring fistula treatment and the number of repairs supported, by country. We are also unable to report the number of *women* repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women.

Figure UGA1: Number of Women Seeking and Eligible for Fistula Treatment, and Number of Surgical Repairs, by Site, FY 15/16



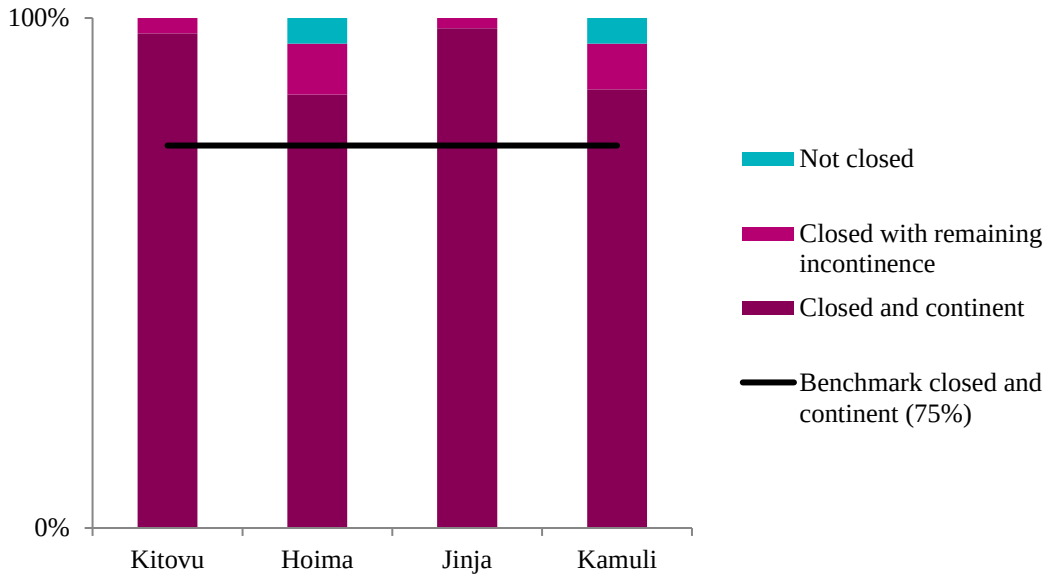
These majority of these 350 surgical repairs (94%) were carried out during concentrated repair efforts, with a small number of routine repairs also provided at Hoima, Jinja, and Kitovu (see Table UGA2 for detail by quarter). FC+/Uganda has made a concerted effort with supported sites to institute and support routine repair services; this fiscal year those efforts have begun to bear fruit, with this small but meaningful number of routine repairs.

Table UGA2: USAID-Supported Surgical Fistula Repairs, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Kitovu Mission Hospital	49	62	50	43	204
Kamuli Mission Hospital	0	0	46	17	63
Hoima Regional Referral Hospital	0	0	34	6	40
Jinja Regional Referral Hospital	0	0	4	39	43
Total	**49**	**62**	**134**	**105**	**350**

During FY 15/16, 99% of all fistula repair surgeries were reported as closed at time of discharge; 94% were closed and continent and 5% were closed and incontinent. This very high rate of optimal outcome (closed *and* continent) may reflect excellent surgical skills, but is also subject to on-going audit, as described in Objective 5 below. Outcomes for discharged patients are presented in Figure UGA2. Reported complications were low (2.9%).

Figure UGA2. Outcome Rates for Surgical Repairs, by Site, FY 15/16



Nearly all diagnosed fistula cases were reported to have an etiology of obstructed/prolonged labor (94.5%), with the remaining 5.5% attributed to iatrogenic causes.

At Kitovu Hospital, during the third quarter, women who had received fistula surgery were given support to aid their social and financial reintegration into their communities following repair. This support included piglets, maize, and other merchandise based on the women's individual needs.

In addition to the surgical repairs reported, 20 women received conservative treatment (catheterization) for fistula at Kitovu (n=15), Jinja (n=4) and Hoima (n=1) during the fiscal year. 95% of these cases were closed and continent at discharge, with the remaining 5% closed and

incontinent. An additional 31 women were treated with pelvic floor exercises during the fiscal year at Kitovu and Kamuli.

FC+/Uganda initiated support to Jinja and Kamuli for the provision of routine POP services. During the second quarter, a site assessment was conducted to ascertain current capacity to provide surgical, inpatient and outpatient services related to POP. Interviews with selected health managers and departmental heads were conducted, coupled with data collection on POP, fistula, FP, inventory, equipment, and maternal and obstetric care. The data collected was analyzed and used to determine the gaps related to sustainable implementation of integrated fistula and POP services at Jinja, continuing fistula services at Kamuli and creating sustainable POP referrals from Kamuli to Jinja.

In the third quarter, Jinja initiated pilot activities to integrate POP services into fistula care, providing training to three surgeons on surgical POP management. Unfortunately, none of the Jinja site surgeons completed their training; the POP consultant had to amend the agenda towards training of nursing staff, who had inappropriately clamped the catheters of all fistula patients early in the post-operative period, requiring repeat surgery for all fistula clients. As a result of lack of engagement of junior surgeon trainees and the knowledge gaps of the ward nurses, the engagement instead became a Clinical Medical Education (CME) session on POP, stress urinary incontinence and overactive bladder for staff from the outpatient department and gynecological wards. Staff also participated in a refresher course on screening of POP patients, and post-operative care provided to obstetric fistula patients.

During FY 15/16, a total of 119 POP treatments were provided at supported sites, with Jinja and Kitovu providing the majority of these treatments (see Table 13, in Section II, Objective 4). Given the lack of engagement of Jinja surgeon trainees, the strategy for POP integration was amended to be carried out at another site, where senior fistula surgeons will work with the POP integration consultant. These senior Ugandan fistula surgeons will then extrapolate the integrated POP-fistula-incontinence skill sets to junior surgeons throughout Uganda, including surgeons at Jinja, over whom the senior Ugandan surgeons exert achievable influence in learning.

There were no surgeons trained in fistula repair during this fiscal year. As part of fistula prevention efforts, FC+/Uganda provided training to 462 health care providers during FY 15/16, Table UGA3 provides totals for non-surgical trainings of health system personnel. Trainings included: infection prevention workshops; EmONC and partograph training for midwives on the correct and consistent use of the partograph for labor monitoring and to implement emergency obstetric procedures to avert and reduce maternal and fetal complications and death; obstetric fistula counseling; strategies and content for community outreach and education and pre- and post-operative care for fistula treatment. As referenced under Objective 2, VHTs in Jinja and Kamuli participated in trainings on community outreach and education for the promotion of maternal health and the prevention of obstetric fistula.

During the first quarter, FC+/Uganda sponsored two obstetrician gynecologists from Jinja Regional Referral Hospital and Kitovu Mission Hospital to attend a structured operative

obstetrics (SOO) skills training that was conducted by the American College of Obstetrics and Gynecology (ACOG) at Makerere University. The SOO training was found to have been very useful and the gynecologists recommended embracing more health providers even in lower level facilities with mandate to provide C-section and promotion of task shifting. In a bid to harness partnerships for quality of care, FC+/Global and FC+/Uganda have been in discussion with ACOG to evaluate these trainings and scale up the training in fistula supported facilities. See Section II, Objective 1 for additional information on this partnership.

Table UGA3: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
C-section skills training	2	0	0	0	**2**
Infection prevention	20	150	0	20	**190**
Partograph and EmONC	0	29	15	49	**93**
Data management	0	40	0	0	**40**
POP and fistula pre- and post-operative care	0	0	30	0	**30**
Fistula counseling	0	0	10	0	**10**
Community outreach and education	0	0	30	27	**57**
Fistula pre- and post-operative care	0	0	0	40	**40**
Total	**22**	**219**	**85**	**136**	**462**

FC+/Uganda supported FP counseling and service provision at 17 sites in Uganda during FY 15/16. Over 24,000 counseling sessions took place at supported sites and 30,087 CYP were provided, see Table UGA4 for detail, by site. Method mix contributing to this CYP in Uganda was primarily implants (52%), IUD (21%), tubal ligation (10%), and Depo Provera (9%). Two FP providers specifically engaged during the Jinja concentrated repair efforts to provide education and counseling to both fistula clients and those accompanying them (family, spouses, friends).

Group family planning counseling session during Kamuli Mission Hospital concentrated fistula repair effort. Credit: FC+ Uganda.

Table UGA4: Family Planning Counseling Sessions and CYP, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP[20]
Azur HCIV	402	943	208	344	278	675	560	1,129	**1,448**	**3,091**
Buraru HCIII	238	187	317	284	355	350	302	238	**1,212**	**1,059**
Buseruka HCIII	270	107	219	159	210	143	245	224	**944**	**633**
Bwera GH	836	1311	584	962	532	527	588	688	**2,540**	**3,488**
Hoima RH	419	492	402	442	564	472	688	651	**2,073**	**2,056**
Jinja RRH	956	1745	744	1169	448	1,144	738	1,320	**2,886**	**5,378**
Kagando	402	627	421	1122	233	620	404	798	**1,460**	**3,167**
Kalungu HCIII	97	119	64	423	134	197	101	44	**396**	**783**
Kamuli	31	0	26	6	232	181	1,606	0	**1,895**	**187**
Karambi HCIII	235	440	240	414	181	363	192	147	**848**	**1,362**
Kigorobya HCIV	306	163	339	368	372	607	500	591	**1,517**	**1,729**
Kikuube HCIV	382	436	408	203	395	462	283	279	**1,468**	**1,380**
Kitovu	56	0	13	0	17	4	9	0	**95**	**0**
Kiyumba HCIV	73	77	121	227	157	252	163	219	**514**	**775**
Kyanamukaka HCIV	143	235	267	359	164	237	285	388	**859**	**1,219**
Masaka RRH	531	497	784	708	834	663	922	1,114	**3,071**	**2,982**
Rwesande HCIV	213	223	189	168	229	173	224	231	**855**	**795**
Total	**5,590**	**7,601**	**5,346**	**7,358**	**5,335**	**7,068**	**7,810**	**8,060**	**24,081**	**30,087**

FC+/Uganda intends to scale up the use of partograph for labor monitoring at lower-level health centers (HC IIIs and IIs) that make referrals to larger hospitals in Kasese District. An assessment was carried out at 11 health facilities to determine the extent of documentation of various parameters on partograph and assess midwives' perception of its use in labor monitoring. At each facility, available partographs were reviewed and using a questionnaire, compiled status of completion and correctness of all parameters. Discussions about experiences of using partographs were also held with midwives and nurses. Findings will inform training and scaling up of partograph use at these facilities. This will improve labor monitoring and facilitate timely referrals in cases of prolonged or obstructed labor. In the long run it is envisaged that this intervention will contribute to reduction of maternal and fetal complications that occur at HC IVs and hospitals as a result of late referral of women with prolonged/obstructed labor.

During a facility assessment exercise in FY 14/15, it was identified that most midwives trained on the use of the partograph had either left or been transferred to other health facilities. Therefore, there was need to train or re-train all maternity staff on the rationale and use of the partograph coupled with on the job mentoring and coaching. During the second quarter of FY 15/16, meetings were held with Facility Managers and in charge maternity wards to discuss the issues related to partograph use and plan for trainings which were subsequently held in the fourth

[20] Due to rounding, totals may differ slightly from the sum of individual quarters.

quarter (see Table UGA3). Routine annual partograph monitoring was carried out during the fourth quarter by FC+ Uganda staff.

Supported sites reported an overall C-section rate of 25% during FY 15/16, based on 75,936 reported deliveries. Information on number of deliveries, by site, is represented in Figure UGA3 and C-section rates, by site, are presented in Figure UGA4. Sites reported that 2.4% of all labors were prolonged/obstructed, 3.6% of which received catheterization for fistula prevention.

Figure UGA3. Number of Obstetric Deliveries, by Site, FY 15/16 (n=75,936)

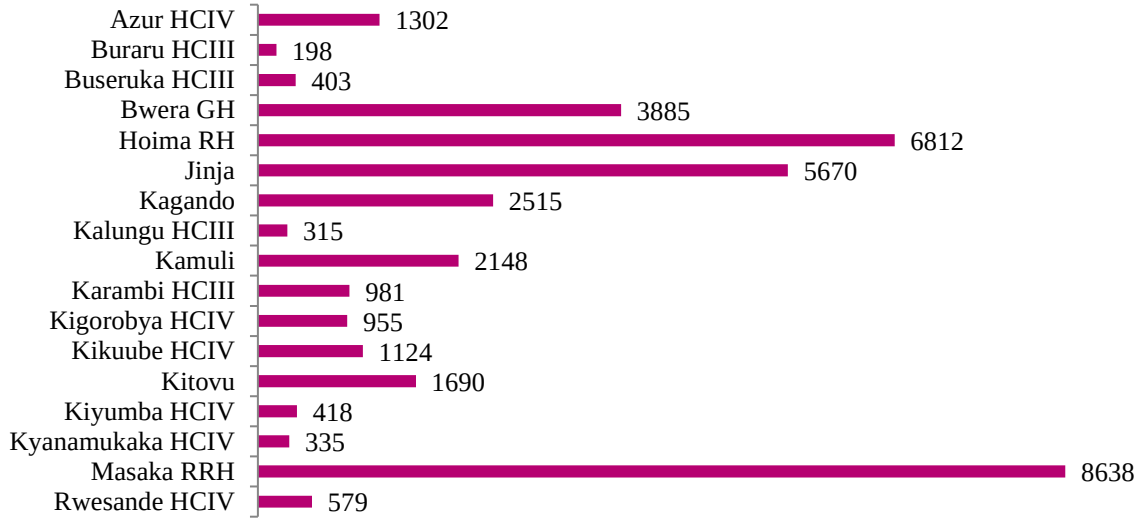
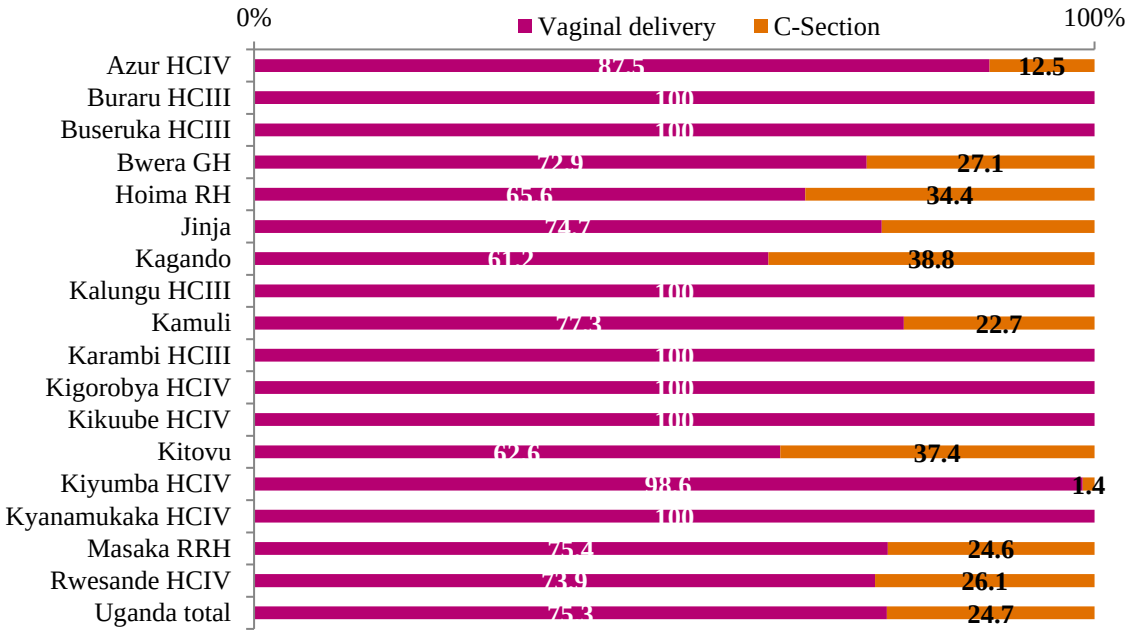


Figure UGA4. C-Section Rates, by Site, FY 15/16



Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

A referenced under Objective 4, FC+ Uganda has undergone data verification exercises to look more closely at the very high closure rates being reported consistently at supported sites. During the first quarter, FC+/EngenderHealth Uganda held its first CDDM meeting that brought together FC+ and ExpandFP staff to review performance of the two projects based on the data collected over the last year (Oct 2014 –Sept 2015). During the meeting, staff observed that Uganda had very high fistula surgery success rates (over 90%) in comparison with other FC+ countries. As a result, in the second and third quarters, an exercise was conducted to verify the very high fistula surgery success rates at discharge with a special focus on Kitovu Mission Hospital and Hoima Regional Referral Hospital.

The FC+ Global Clinical Team supported the development of a client tracker tool, as part of the FC+ Surgical Safety Toolkit, to help in verifying levels of accuracy of success rates reported at the time and clinical practices that may have contributed to the success rates. Two independent consultants (a MoH fistula surgeon and a counselor) were engaged to collect data using the two tools. Data collection was completed; and analysis, report writing, and sharing is ongoing. This data will also be used in the development of abstracts for the upcoming ISOFS conference in Abuja in October 2016.

FC+ Uganda also sponsored the attendance of 40 participants, primarily staff from supported fistula treatment sites, at the first National Obstetric Fistula Scientific Conference held in Kampala during the fourth quarter of FY 15/16. The conference was attended by over 300 people, and had the theme of "End Fistula Within a Generation, Create Awareness Now." More than 20 members of parliament participated in this conference, including representatives from the public health committee. 12 abstracts were presented representing FC+ efforts including treatment and prevention, community interventions and religious leaders' involvement in fistula activities. All abstracts presented were also submitted and accepted for presentation at the upcoming ISOFS conference in Abuja in October, 2016.

In addition to the internal data for decision making (DDM) exercises now conducted quarterly by the project, data quality assurance exercises take place at supported sites throughout the fiscal year, together with health workers from various departments including FP, maternity, medical records, surgical, antenatal, management as well as relevant district biostatisticians and HMIS personnel. Findings are shared with the staff and medical records teams at the facilities in efforts to improve service delivery as well as data quality. During FY 15/16, 100% of supported treatment sites were able to meet at least once to review data and utilize it for planning and decision-making; one site (25%), Hoima, was able to meet at least twice.

A clinical DDM (CDDM) training workshop was conducted at Jinja Regional Referral Hospital and Kamuli Mission Hospital, see Table UGA3, to equip health workers at the health facility

with knowledge and skills in HMIS data management practices and utilization for informed decision making. A total of 40 participants from maternity, OPD, administration, medical ward, theatre, and medical records were involved in the training. FC+/Uganda also donated two full computer sets to the facilities, as well as to Masaka Regional Referral Hospital, to support HMIS data compilation processes and timely reporting.

During the third quarter, two FC+ Uganda staff participated in the EngenderHealth CDDM meeting held in Addis Ababa in June 2016.

Collection and reporting of data on catheterization and obstructed labor at health facilities was found to be a challenge due to the fact the MoH HMIS tools don't have provisions for those data items. It was agreed that health workers will be oriented on how to capture these data in clinical notes of each client so that at the end of the month the Maternity Unit in Charge is able to compile the total number of women who were catheterized and those who experienced obstructed labor.

The Ugandan MoH undertakes revision of all HMIS data collection and reporting tools periodically to incorporate new data variables and delete those rendered redundant based on identified data needs. The most recent revision exercise took place in July 2015. A quick assessment carried out in September 2015 revealed that almost all FC+ supported facilities were yet to receive and start using the revised FP registers. The project supported the printing and dissemination of 49 registers, monthly tally and summary sheets to all the 17 facilities. The M&E team working alongside district HMIS focal persons to orient health workers and medical records personnel at each facility. This activity was cost shared between FC+ and the ExpandFP project.

In addition to HMIS tool dissemination, FC+/Uganda supported the MoH to disseminate fistula prevention and treatment guidelines, data collection tools, and the National Fistula Strategy at five fistula treatment sites (Mbarara Regional Referral Hospital (RRH), Bwera General Hospital, Kagando Mission Hospital, Jinja RRH, and Kamuli Mission Hospital). At each site, fistula teams including surgeons, nurses, and theatre staff were oriented on how to use each of the tools and several copies were handed over for use. This will greatly contribute to standardizing fistula care and data collection thereby strengthening quality of care and data use.

FC+/Uganda has begun the process of developing a project level database that will enable more meaningful analysis of the fistula data captured through the MoH fistula registration forms at supported sites. It is also intended to capture client follow-up information and mortality data. FC+ Uganda has been exploring vendors and technological approaches for the database and expects it to be finalized in the beginning of FY 16/17.

Research on women with incurable fistula (WIF) [21], with FC+ partner TERREWODE, continues to move forward. During the first quarter, the research protocol and translation of data collection tools were completed and submitted to Makerere University School of Medicine for ethical

[21] This is the term that has been adopted by national fistula actors in Uganda, preferred locally over WDI.

approval. Ethical approval from Makerere and the Uganda National Council of Science and Technology was received in the second quarter. Recruitment and training of research assistants took place in the third quarter, along with identification of the WIF which was conducted utilizing strategies including consultation with fistula surgeons to access medical records at different treatment sites in Uganda and collaboration with fistula support groups based at the community level to reach out to suspected women and girls with incurable fistula. Identification efforts were concentrated in the study areas of Teso and Busoga in Eastern Uganda, Bunyoro in Western Uganda, Buganda in Central Uganda and Lango in Northern Uganda.

During the fourth quarter, TERREWODE completed both the 1st and 2nd phase training of WIF at the TERREWODE's Women's Economic Empowerment and Self-Reliance (WEES) center. 30 participants from the study areas of Teso and Busoga in Eastern Uganda, Bunyoro in Western Uganda, Buganda in Central Uganda and Lango in Northern Uganda participated in the first phase, with three women dropping out in the second phase for a total of 27 women participating in both phases. Participants also took part in field exposure visits to selected model successful farms in eastern and central Uganda. Criteria for selecting the farms included those founded by a woman or group of women, having a woman as the primary manager, those started with minimal start-up capital comprised mainly of personal savings and those that have had international exposure.

Also during the fourth quarter, a training was carried out for 20 community volunteers who are to act as "sister friends" to the study participants. These volunteers were screened and selected by TERREWODE staff, including discussion with the study participants, consultation with TERREWODE's Obstetric Fistula Advocacy and Awareness Network (OFAAN) members (particularly reintegrated women) and with the VHTs.

Finally, during the fourth quarter, strategic community groups were identified to establish linkages between the WIF and community resources that will help them achieve success in reintegrating into their communities, taking their individual skills and interests into account.

West Africa /Niger

EngenderHealth began support for fistula services in the West Africa Region with implementation of a BMGF grant in Niger in 2005. USAID-supported fistula services in the region began in 2007 through the AWARE and FC projects and continue through FC+ in Niger in four treatment and prevention sites and four prevention-only sites as of September 30, 2016. FC+ efforts in Niger are part of a larger West Africa regional focus with the goal of continuing to build Niger as a regional hub for learning and a model for FP/fistula integration activities, education, research, advocacy, and best practices. Emphasis is on collaboration with regional partners to strengthen fistula prevention, treatment, and reintegration efforts throughout West Africa. In FY 14/15, FC+ initiated activities in Togo. Niger-based and regional project efforts are reported here; activities in Togo are reported in a separate country report, below.

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors

The "Reseau pour l'eradication de la fistule" (REF) is an important partner for FC+ in West Africa/Niger (FC+/WAN). The REF was jointly established by the Ministry of Health and the Ministry for Women and Children's Protection and includes representatives from civil society. It brings technical support and human resources in the prevention, management, and socioeconomic reintegration of women suffering from fistula. Under the previous FC project, activities were primarily implemented by REF. Under FC+, a project management structure has been established and an MOU describing the partnership between FC+ and REF has been implemented.

During FY 15/16, FC+ has successfully supported REF's on-going efforts to mobilize obstetric fistula specialists and involve them in the revision of a National Obstetric Fistula Strategy. This strategy is to act as a guide for regional efforts towards fistula prevention, treatment and reintegration efforts. A meeting for development of the initial draft of the national strategy meeting was postponed in December 2015 due to partner constraints. A workshop, organized by REF, for the finalization of the logical framework of the national strategy to eradicate female genital fistula in Niger was held in February 2016, and a meeting on drafting the initial strategy was held in March 2016. The focus of this meeting was on how to create an enabling environment to a holistic care for women at risk for or living with fistula in order to eradicate fistula and contribute to the reduction of maternal mortality and morbidity under the Sustainable Development Goals.

During the third quarter of the fiscal year, as part of a national forum involving all partners working on fistula at the national and regional level, the revised National Obstetric Fistula Prevention and Control Strategy and five-year action plan were finalized and adopted. A validation workshop was held during the fourth quarter, in collaboration with the MOH. The action plan will receive financial support from all involved partners.

This national strategy has four main strategic areas of intervention:

- Fistula prevention;
- Strengthening of fistula repair health center capacity, including the quality of services to be offered to clients;
- Social reintegration for cured clients and women deemed incurable;
- REF coordination and lessons learned development approach

Efforts to develop a regional policy for fistula prevention with the authorities of the Organization of African States (OAS) were initiated with the MOH and REF during FY 15/16. A concept note was developed and REF has taken the lead role in moving discussions forward. FC+/WAN and REF attempted to facilitate discussion and planning between the MOH and WAHO to plan for upcoming exchanges and to advocate for the finalization of a regional strategy and regional data collection tools for addressing obstetric fistula. After multiple attempts to contact WAHO, the MOH was informed that fistula activity falls under the auspices of the ECOWAS Commission of Social Affairs and Gender, and that a regional workshop organized by the UNFPA regional office had taken place in June 2015 during which an action plan for obstetric fistula was developed. ECOWAS has requested that all countries in the region should refer to this regional plan and use it as a guide for development of national plans, where needed. Once this information was communicated, the project recommended that the MOH initiate discussions with WAHO to discuss this regional plan and determine how to ensure its dissemination more widely to relevant stakeholders.

The First Lady of Niger, Dr. Malika Issoufou, officially launched the commemoration of the International Day to End Obstetric Fistula (IDEOF) at supported site CNRFO in May 2016 (see Appendix U for a full summary of all FC+ IDEOF activity). Approximately 300 community members and officials were on hand for the celebration.

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

FC+/WAN is employing a community engagement strategy to build on the success of the FC project's work with Village Safe Motherhood Committees. In the fourth quarter, the project debuted the Site Walk Through (SWT) approach in Niger, introducing a new component to the community engagement approach. Details are provided below.

FC+/ WAN's community mobilization activities in FY 15/16 focused on training and then supporting community volunteers who provide house to house community outreach with messaging on safe birth practices, FP, and fistula treatment and prevention. 414 community volunteers were trained during FY 15/16: in the first quarter of the fiscal year, 54 community

Training of community volunteers in Illela, April 2016. Credit: FC+/WA/Niger

volunteers were trained in Gabi, where the health center has substantial experience with fistula activities, and Guidan Roumji, a suburban health center with a large catchment area, see Table WA/N1. As described in Objective 4, trainers trained during this period went on to then carry out cascade training in the third quarter for 360 community volunteers in the districts of Bouza and Illela. Post-training follow-up monitoring took place throughout the year with all the teams of trained volunteers; there are now a total of 774 community volunteers who have been trained by the project.

Table WAN1: Community Volunteer/Educator Training, Participants by Topic, By Quarter, FY 15/16

Type of Training	Oct-Dec 2015	Jan-Mar 2016	Apr-Jun 2016	Jul-Sept 2016	Total FY 15/16
Community volunteers	54	0	360	0	414
Total	**54**	**0**	**360**	**0**	**414**

In FY 15/16, the project expanded community engagement activities in the Tahoua region in response to reported increasing numbers of fistula cases in the REF database. Activities continued in Madarounfa and Guidan Roumji, and expanded to Illela and Bouza during the third quarter, after the trainings described above in Table WAN1. Community sensitization activities were conducted using door-to-door visits, small and large group meetings, at the mosque, and at market places.

7,494 outreach sessions reached 242,416 participants during FY 15/16, see Table WAN2. The sessions covered topics including: understanding obstetric fistula, essential actions for safe motherhood, maternal health care, factors related to home delivery, definition of a maternal death and recognition of danger signs, essential actions to take to safeguard maternal health, the importance of community involvement in the monitoring of mother's health and the promotion of the use of health care, the importance of male involvement in maternal health, and danger signs during pregnancy. The volunteers utilize communications materials and awareness-raising kits which include fabrics with messaging images printed upon them, prepared by the project for community sensitization on fistula prevention.

In the final quarter of the fiscal year, FC+ piloted the SWT approach in four sites in the Maradi and Tahoua regions: Garadoume, Tajae, Chadakori and Guidan Roumji. This approach is intended to catalyze community participation in health and strengthen the accountability of service providers to communities. It also fosters linkages and partnerships between health providers and community members, who can together identify and address barriers to providing and accessing high quality services. A SWT is a guided tour of a health facility for community representatives of that site’s catchment area, which includes review of site service statistics as a starting point for exploring priorities and barriers from the community perspective. Significant preparation was required for the SWTs, including use of external consultants for collection and analysis of service statistics. Following the tours, action plans were developed by participants and progress will be followed on an on-going basis.

FC+/WAN hosted a Gender 101 training at the end of FY 14/15 which included participants from subaward partners in DRC. During FY 15/16, the FC+/WAN team has reported an increased focus on gender work at various levels, with the support of the FC+ Gender Focal Point, including: review of the community volunteer training curriculum to ensure inclusion of information on gender, power, and men as partners in birth planning and other aspects of maternal health; ensuring that SBCC materials do not reinforce negative stereotypes or social norms; reviewing planned FY 16/17 activities to ensure that they are gender sensitive and/or transformative in nature.

Table WAN2: Community Outreach/Education/Advocacy Events, By Quarter, FY 15/16

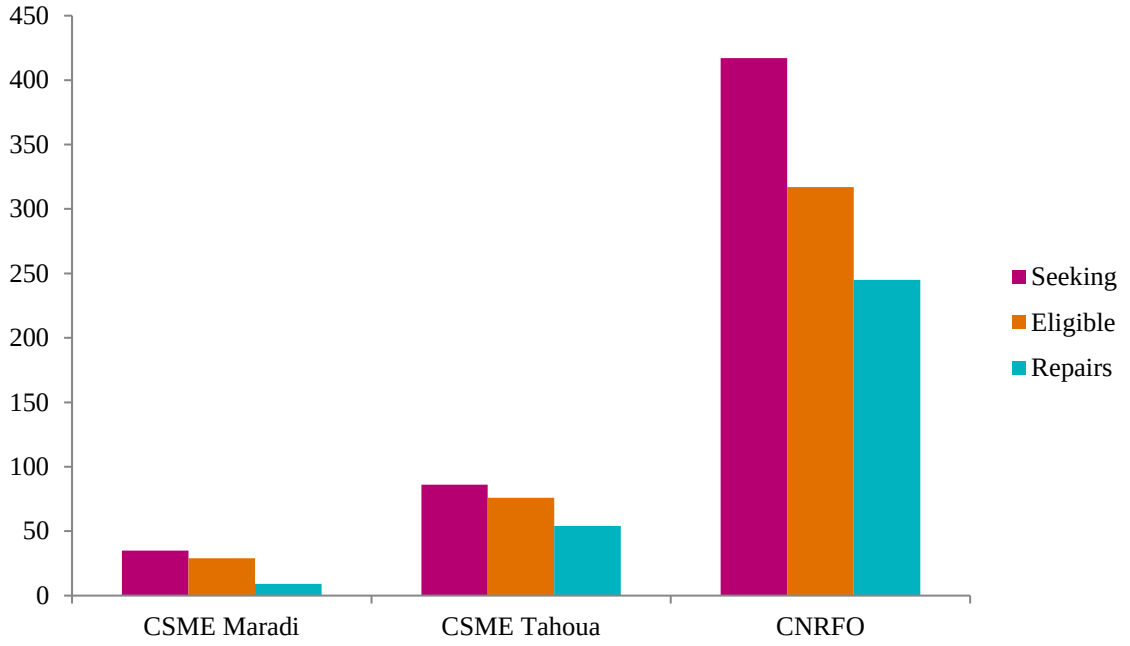
Type of Event	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	# Events	# Reached	# Events	# Reached	# Events	# Reached	# Events	# Reached	**# Events**	**# Reached**
Existing community activity	1,033	43,348	1,153	41,475	2,697	80,495	2,607	76,215	**7,490**	**241,533**
Health facility	0	0	0	0	1	300	0	0	**1**	**300**
Health providers	0	0	0	0	0	0	0	0	**0**	**0**
Policy makers	0	0	0	0	0	0	0	0	**0**	**0**
Maternal health/ fistula-focused	2	383	0	0	1	200	0	0	**3**	**583**
Radio/TV	0	0	0	0	0	0	0	0	**0**	**0**
Total	**1,035**	**43,731**	**1,153**	**41,475**	**2,699**	**80,995**	**2,607**	**76,215**	**7,494**	**242,416**

Two FC+/WAN staff members attended the SBCC Summit and Objective 2 Experts' workshop held in Ethiopia in February 2016.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

During FY 15/16, 538 women with severe incontinence symptoms arrived seeking fistula care at FC+ supported sites in Niger, of which 441 were diagnosed with fistula and required treatment (82%). Of those diagnosed with fistula, 422 (96%) were medically eligible for surgery. FC+/WAN supported 308 fistula repair surgeries during this reporting period (73% of those eligible). Some women may be diagnosed with fistula in one quarter, and repaired in the next. Because FC+ does not track individual women through our data collection, we are unable to present a definitive percentage of women requiring repair who receive it. We are also unable to report the number of women repaired because women may have multiple repairs over the life of project, or repairs at multiple sites. However, within a given quarter, the number of repairs generally reflects the number of women. Figure WAN1 presents data on women seeking and requiring fistula treatment, and the number of fistula surgeries supported, by site.

Figure WAN1: Number of Women Seeking and Eligible for Fistula Treatment, and Number of Surgical Repairs, by Site, FY 15/16



These 308 fistula repair surgeries were conducted via routine services at three FC+/WAN supported sites: CSME Maradi, CSME Tahoua, and CNRFO, see Table WAN3 for detail by quarter. UNFPA also provides support to some of the sites in Niger supported by FC+; therefore, REF coordinates which fistula repairs are reimbursed by each donor to ensure transparency and avoid double-counting. Dimol, a local NGO working on obstetric fistula identification and integration, has been a helpful partner in referring cases to CNRFO for repair.

Throughout the fiscal year, there was a national strike of medical specialists which negatively impacted the ability to provide services. Also, the fistula surgeon of CSME Tahoua retired during this fiscal year. His replacement was trained at CNRFO and took over the position in the fourth quarter. A concentrated repair effort for clients with complex surgery was concurrently planned with FIMA (Festival International de la Mode Africaine), a biennial fashion conference. Postponement of the conference due to security concerns, as well as unavailability of the medical team leader, has delayed the repair of these clients from Tahoua and Maradi.

In addition to the surgical repairs reported above, 32 women received conservative treatment (catheterization) for fistula at the three supported treatment sites, with two-thirds of those taking place at CSME Tahoua. 31% of these cases were closed and continent at discharge, 16% closed and incontinent and 53% were not closed.

Clinical monitoring visits took place at all supported sites, as well as medical waste monitoring, during the fourth quarter of the fiscal year.

Table WAN3: USAID-Supported Surgical Fistula Repairs, by Site, By Quarter, FY 15/16

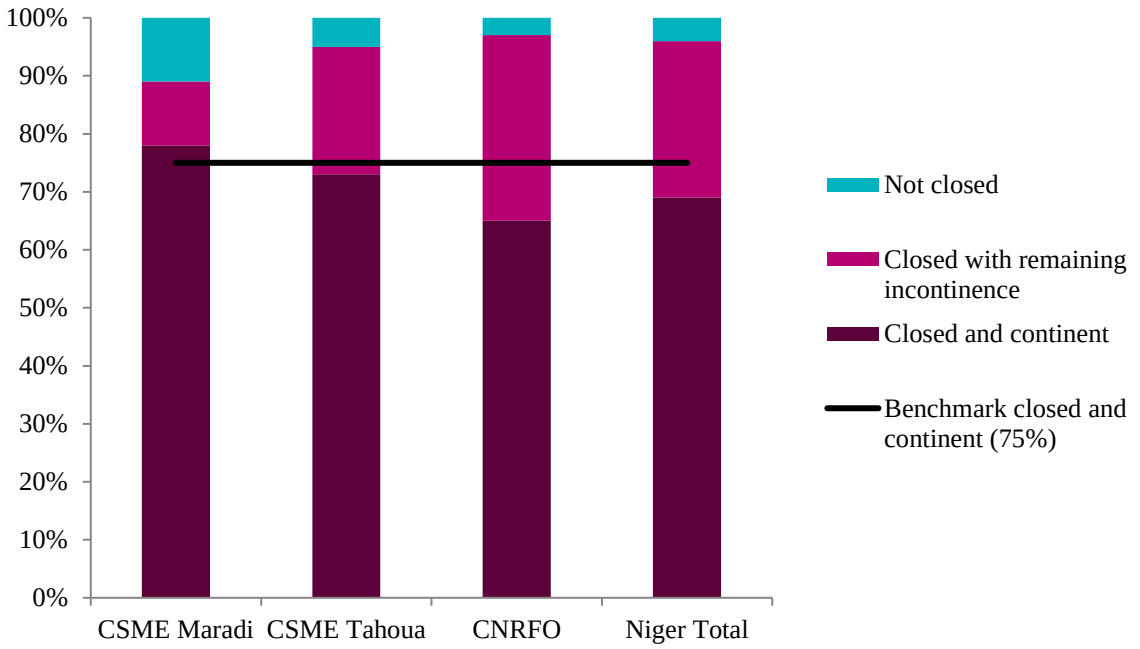
Site	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
CSME Tahoua	12	14	2	26	54
CSME Maradi	3	5	1	0	9
CNRFO	32	91	63	59	245
Total	**47**	**110**	**66**	**85**	**308**

Etiology information was available for 402 (91%) of the 441 diagnosed fistula cases in FY 15/16. The vast majority of these cases (96%) were identified as resulting from obstructed/prolonged labor, iatrogenic fistula represented 3% of all cases, and less than one percent of cases were due to cancer.

Data on the complexity of the fistula was available for all 129 cases discharged during the reporting period. Of these, 61% were classified as simple fistula and 39% as not simple.

In FY 15/16, 96% of all fistula surgery cases were closed at time of discharge; 69% were closed and continent and 27% were closed and incontinent. Outcomes for discharged patients are presented, by site, in Figure WAN2. No complications were reported at supported sites.

Figure WAN2. Outcome Rates for Surgical Repairs, by Site, FY 15/16



There were no surgeons trained during FY 15/16.

Infection prevention training at CSME Maradi. Credit: FC+/West Africa/Niger

FC+/WAN supported training for 93 non-surgical health personnel during FY 15/16 (see Table WAN4). These trainings took place at CSME Maradi and Tahoua and covered topics including: facilitative supervision, use of the partograph, COPE, EmONC and infection prevention. In the second quarter, as part of fistula prevention efforts, FC+/WAN supported a training of trainers for 15 health facility staff in Illela and Bouza who then carried out cascade trainings for community volunteers in Bouza and Illela during the third quarter (see Objective 2). This TOT covered topics including fistula repair, FP, training and community mobilization.

Table WAN4: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Community outreach and education TOT	0	15	0	0	**15**
Facilitative supervision	0	0	18	0	**18**
Partograph and EmONC/COPE	0	0	20	20	**40**
Infection prevention	0	0	0	20	**20**
Total	**0**	**15**	**38**	**40**	**93**

During FY 15/16, 792 FP counseling sessions took place at two supported sites and 4,324 CYP were provided, see Table WAN5 for detail, by site. Method mix at supported sites in Niger primarily consists of implants (44% of all CYP), followed by injectables, oral pills, tubal ligation, male condoms, and IUDs.

Table WAN5: Family Planning Counseling Sessions and CYP, by Site, By Quarter, FY 15/16

Site	Oct-Dec 2015		Jan-Mar 2016		Apr–Jun 2016		Jul-Sep 2016		Total FY 15/16	
	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP	#sessions	CYP[22]
CSME Tahoua	81	154	115	220	163	220	162	281	**521**	**876**
CSME Maradi	67	904	122	929	65	817	17	798	**271**	**3,448**
Total	**148**	**1,058**	**237**	**1,149**	**228**	**1037**	**179**	**1079**	**792**	**4,324**

FC+/WAN supported sites reported an overall C-section rate of 51% (n=5,072 deliveries) in FY 15/16. Information on number of deliveries, by site, is represented in Figure WAN3 and C-

[22] Due to rounding, totals may differ slightly from the sum of individual quarters.

section rates, by site, are presented in Figure WAN4. Sites reported 18% of all labors were prolonged/obstructed and 46% of those labors received catheterization for fistula prevention.

Annual partograph monitoring took place at supported sites during the fourth quarter of the fiscal year.

Figure WAN3. Number of Obstetric Deliveries, by Site, FY 15/16 (n=5,072)

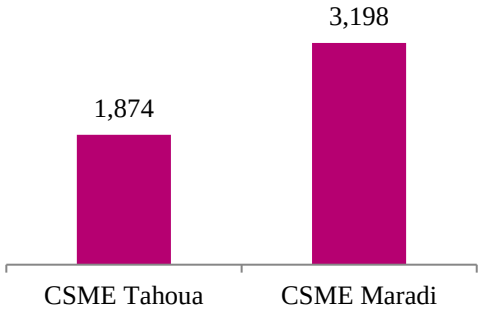
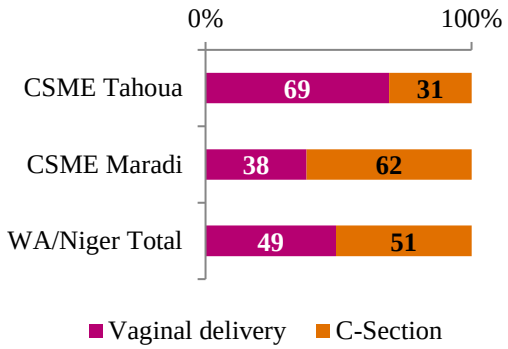


Figure WAN4. C-Section Rates, by Site, FY 15/16



Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

FC+/WAN has developed a database to help track routine data monitoring. In addition to quarterly site visits and data discussions, as part of efforts to improve the availability of data and application of standard monitoring and evaluation indicators, adapted data collection forms were developed and distributed to community volunteers. These forms are used for collecting information from health centers at the community level and for reporting data to the district level. Quarterly meetings are being held with community volunteers, as well as all supported sites, to collect, review and analyze data together.

FC+/WAN has initiated discussions with REF to support development and management of a national fistula repair database.

Dr. Sanda Ganda was supported to attend and present on iatrogenic fistula at Global Maternal and Newborn Health Conference in October 2015. The FC+/WAN M&E officer attended the EngenderHealth CDDM meeting, as well as the follow-on one-day FC+ meeting, in Addis Ababa in June 2016.

During FY 15/16, 100% of supported treatment sites met each quarter (for a total of four times/year for each site) to review data and utilize it for planning and decision-making; the FC+/WAN M&E officer facilitates these meetings each quarter with site staff.

West Africa/ Togo

During FY 14/15, FC+ initiated activities in Togo through site assessment, clinician training, and provision of support to a Guinean surgeon to participate in a UNFPA-sponsored fistula repair camps in Togo. In FY 15/16, activities were carried out in the first quarter of the year and included training and support for surgical care through one concentrated repair effort at CHR Sokode. Additional activities in Togo are contingent upon the hire of a physician clinical officer in the Niger office who will take over coordination of Togo activity external consultants. Further activity in Togo is also on-hold until the FC+ Safe Surgery Toolkit is rolled out in FY 16/17.

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

In the first quarter, FC+/West Africa/Togo (WAT) supported one surgeon from Guinea, Dr. Kindy Diallo, to attend and lead UNFPA-sponsored fistula repair camps at CHR Sokodé in Togo. These 30 repairs were supported by UNFPA and are therefore not included in the report of USAID-supported repairs. However, CHR Sokodé is considered an FC+ supported site, as shown in Appendix A.

In addition, nine nurses received follow up training and on the job support for counseling skills and infection prevention, see Table WAT1.

Table WAT1: Non-Surgical Health System Personnel Training, Participants by Topic, By Quarter, FY 15/16

Topic	Oct-Dec 2015	Jan-Mar 2016	Apr–Jun 2016	Jul-Sep 2016	Total FY 15/16
Fistula Counseling and IP	9	0	0	0	**9**
Total	**9**	**0**	**0**	**0**	**9**

APPENDIX A: FC+ PLANNED AND ACTUAL SUPPORTED SITES, BY COUNTRY

Country/Site	Sector	Planned FY 15/16 T: Treatment & Prevention P: Prevention-only	Actual FY 15/16
Bangladesh: 11 sites		**8T, 3P**	**8T, 3P**
Ad-Din Dhaka	Private	T	T
Ad-Din Jessore	Private	T	T
Ad-Din Khulna	Private	T	T
Kumudini Hospital	Private	T	T
LAMB Hospital	FBO	T	T
Bangabandhu Sheikh Mujib Medical University	Government	T	T
Dr. Muttalib Community Hospital	Private	T	T
Mamm's Institute of Fistula & Women's Health	Private	T	T
Hope Foundation Hospital, cox's Bazar	Private	P	P
Jhalokathi District Hospital	Government	P	P
Hobiganj District Hospital	Government	P	P
DRC: 5 sites		**5T**	**5T**
St. Joseph's Hospital/Satellite Maternity Kinshasa	FBO	T	T
Panzi Hospital	FBO	T	T
HEAL Africa	FBO	T	T
Imageri Des Grands-Lacs	Private	T	T
Maternité Sans Risque Kindu	Private	T	T
WA/Niger: 8 sites		**4T, 4P**	**4T, 4P**
Centre de Santé Mère / Enfant (CSME) Maradi	Government	T	T
Centre National de Référence des Fistules Obstétricales (CNRFO),Niamey	Government	T	T
Centre de Santé Mère /Enfant (CSME) Tahoua	Government	T	T
Hopital National Lamorde (HNL)	Government	T	T
Madarounfa District Hospital, Maradi	Government	P	P
Guidan Roumji District Hospital, Maradi	Government	P	P
Bouza District Hospital	Government	P	P
Illela District Hospital	Government	P	P
Nigeria: 783 sites		**13T, 770P**	**15T, 768P**
General Hospital, Ningi	Government	T	T
General Hospital, Ogoja	Government	T	T
National Fistula Center, Abakaliki	Government	T	T
Laure VVF Center	Government	T	T
National Fistula Center, Babbar Ruga, Katsina	Government	T	T
Gesse VVF Center, Birnin Kebbi	Government	T	T
Sobi Specialist Hospital, Ilorin	Government	T	T
Maryam Abatcha Women and Children's Hospital, Sokoto	Government	T	T
Faridat General Hospital, Gusau	Government	T	T
University College Hospital, Ibadan	Government	T	T
Jahun VVF Center, Jigawa State	Government	T	T
Adeoyo General Hospital, Ibadan	Government	T	T
Gambo Sawaba General Hospital, Kofar Gayan, Zaria, Kaduna State	Government	T	T

Country/Site	Sector	Planned FY 15/16 T: Treatment & Prevention P: Prevention-only	Actual FY 15/16
Pope John Paul II Family Life Centre VVF and Maternal Injuries Hospital, Uyo, Akwa Ibom State	Faith-Based	-	T
Evangel VVF Centre, Jos, Plateau State	Government	-	T
Prevention only sites	Government	270P	268P
Former TSHIP sites	Government	500P	500P
WA/Togo: 1 site		**1T**	**1T**
CHR Sokodé	Government	T	T
Uganda: 18 sites		**4T, 13P**	**4T, 14P**
Kitovu Mission Hospital	FBO	T	T
Kamuli Mission Hospital	FBO	T	T
Hoima Regional Referral Hospital	Government	T	T
Masaka Regional Referral Hospital	Government	P	P
Jinja Regional Referral Hospital	Government	P	T
Bwera General Hospital	Government	P	P
Kiyumba HC IV	Government	P	P
Kyanamukaka HC IV	Government	P	P
Kalungu HC III	Government	P	P
Karambi HC III	Government	P	P
Kigorobya HC IV	Government	P	P
Azur HC IV	FBO	P	P
Buseruka HCIII	Government	P	P
Kikuube HCIV	Government	P	P
Buraru HCIII	Government	P	P
Rwesande HCIV	FBO	P	P
Kagando Hospital	FBO	T	P
Lukolo HCIII	Government	-	P
USAID Supported, Non Fistula Care *Plus* IntraHealth (Mali) Jinnah Post Graduate Medical Center (Pakistan) Pathfinder (Ethiopia) PROSANI (DRC) Vodafone/CCBRT (Tanzania)			**14T, 40P** 5T, 39P 1T NA 1T 7T, 1P
TOTAL USAID supported FC+ = 6 Countries		**35T, 790P = 825 sites**	**37T, 789P= 826 sites**
TOTAL USAID supported, bilateral (non FC+) = 5 Countries			**14T, 40P = 54T sites**
TOTAL USAID supported, All Projects = 10 countries			**51T, 829P = 880 sites**
Non-USAID Supported, EngenderHealth Guinea: Kissidougou District Hospital Labe Regional Hospital Jean Paul II Hospital	 Government Government Government	**3T** T T T	**3T** **T** **T** **T**
TOTAL EngenderHealth supported, All Funds= 7 countries		**38T, 790P = 828 sites**	**40T, 789P = 829 sites**
T: Treatment and Prevention, P: Prevention-only			

APPENDIX B: FC+ PARTNERSHIPS, BY COUNTRY[23]

Country	Partners	Nature of Partnership
Bangladesh	Government of Bangladesh	
	Ministry of Health and Family Welfare (MOHFW)	Endorsement and dissemination of National Fistula Strategy and National Action Plan, participation in National Task Force on Obstetric Fistula, Vouchers
	Directorate General of Health Services (DGHS)	National Task Force and Action Plan development, Government Medical College and District Hospitals, partograph use, C-Section, strengthening HMIS, surgical training
	Directorate General of Family Planning (DGFP)	FP integration, community outreach
	Ministry of Social Welfare (MOSW) and Ministry of Women and Children's Affairs (MCWC)	Reintegration, WDI
	Quality Improvement Secretariat (QIS), Health Economics Unit, Ministry of Health	Establishment of Technical Committee on Fistula
	Obstetrical and Gynecological Society of Bangladesh (OGSB)	Partograph use, C-Section
	UNFPA	National Task Force, strengthening HMIS, policy, Increase treatment capacity, Surgical training
	Bangladesh Rural Advancement Committee (brac) and NGO Health Delivery Service Program (NHSDP)	Community outreach
	Direct Relief International	Drugs and medical supplies
	Hope Foundation Hospital	Strengthening HMIS and FP services
	Save The Children (MaMoni)	BMMMS implementation
	ICDDRB	BMMMS implementation
DRC	Ministry of Health	Fistula prevention and treatment Coordination SMNEA (Health of the Mother, Newborn, Child and Adolescent) Task Force Dissemination of SMNEA standards and guidelines
	Access to Primary Health Care Project (ASSP) (DFID)	Fistula prevention and treatment, Community outreach
	PROSANI Plus (Projet de Santé Intégré), Integrated Health Project (IHP), USAID	Fistula prevention and treatment
	UNFPA	Fistula prevention and treatment
	Direct Relief International	Drugs and medical supplies
WA/Niger	Ministry of Health	Coordination, strategy
	Centre National de Référence des Fistules Obstétricales (CRNFO)	Training, treatment and research
	Agir pour la Planification Familiale (AgirPF)	Fistula prevention, coordination
	UNFPA	Fistula prevention and treatment
	Community committees	Community outreach
Nigeria	Federal Ministry of Health (Fistula Desk Office)	Coordination
	UNFPA	Coordination with ongoing activities
	Médecins Sans Frontières (MSF)	Referral and coordination

[23] This list reflects partnerships during FY15/16. This list does not include supported sites or other fistula projects supported by USAID bilateral funds.

	Media, CBOs, Women's Groups, Ward Development Committees, Religious Leaders, Transport Unions. Traditional Rulers	Community outreach
	Population Council	Barriers to treatment
	National Obstetric Fistula Working Group	National fistula prevalence study
	Dimagi	mHealth application
	Radio Nigeria (FRCN)	Public-private partnerships
	Uni-Gloves	Donation of antiseptics and disinfectants
	Islamic Medical Association of Nigeria	Coordination and support for pooled fistula repair efforts
WA/Togo	Ministry of Health	Fistula treatment
	UNFPA	Fistula treatment
Uganda	Ministry of Health(MoH) including all FC+ supported public facilities	Fistula prevention and treatment, National technical working groups PPFP integration into National Program Review of National RH Policy guidelines
	Ministry of Education, Sports, Science and Technology	Capacity building for midwifery tutors Possible collaborative partnership to support adolescent/youth reproductive health programming for the youth in school.
	District Health Offices (Masaka, Kasese, Kalungu, Hoima, Jinja, Kamuli)	Fistula prevention and treatment interventions Quality improvement in facilities
	TERREWODE	Social reintegration, particularly with WDI/Persistent fistula-related disorder
	AMREF	Fistula prevention and treatment
	Population Council	Barriers to treatment
	Direct Relief International	Drugs and medical supplies
	UNFPA	Fistula prevention and treatment
	UHMG	FP Commodities
	Village Health Teams, Religious groups, Women's groups	Community outreach and sensitizations
	Parliament of Uganda –Uganda Women Parliamentary Association, National (Members of parliament), District and local Political leaders, the media	Advocacy on maternal health issues including fistula Community outreaches and mobilization for prevention and treatment
	JPHIEGO	Postpartum FP programming including capacity building of health workers,
	Ministry of Gender, Labour and Social Development	Integrating gender into advocacy for obstetric prevention
	PNFP Hospitals (Kitovu and Kamuli Mission Hospitals)	Fistula prevention and treatment
	Radio stations	Public-private partnerships Promoting fistula awareness
	Private Education Development Network (PEDN)	Implementation of youth-focused interventions
	FHI	Communications initiative

APPENDIX C: ENGENDERHEALTH EVENTS AT WOMEN DELIVER 2016

Concurrent Session Title: The Forgotten Challenge: Maternal and Newborn Morbidity
Date/Time/Venue: Wednesday, May 18 from 3:00pm – 4:00 pm**.** B3-1, Bella Center

Overview: How can overburdened health systems reduce maternal and newborn morbidities? The session will explore lessons from managing prolonged/obstructed labor, first-hand experiences of a young Bangladeshi midwife, linkages between newborn morbidity and country of birth, and reflections from a West African physician tackling maternal/newborn complications at a busy urban hospital.

Speakers

- Dr. Lauri Romanzi, Director, Fistula Care *Plus*, EngenderHealth
- Ruma Khatun, RN, BSN with DFID/ brac University, Developing Midwives Project
- Dr. Hannah Blencowe, Lecturer, London School of Health and Tropical Medicine
- Dr. Charlemagne Marie Ouedraogo, Professor of Medicine, University of Ouagadougou
- Ulla Muller, President and CEO, EngenderHealth (*Moderator*)

Side Event Title: Safe Surgery: A Non-Negotiable for Women's Health, Equity, and Wellbeing?

Date/Time/Venue: Thursday, 19th May 2016 from 7:00am – 8:00am. B4-5, Bella Center.

Overview: Access to safe, affordable, and quality surgical care is a critical but often neglected component of meeting basic health needs worldwide. Join an engaging breakfast and dialogue exploring the intersection of safe surgical care and women's well-being, economic productivity, and equality.

Speakers

- **Dr. Denis Mukwege**, Founder and Medical Director of Panzi Hospital, Democratic Republic of the Congo
- **Erin Anastasi,** Director of UNFPA Campaign to End Fistula
- **Dr. Luc de Bernis**, Independent Consultant, Reproductive, Maternal, and Newborn Health; and Retired Senior Maternal Health Advisor, Technical Division, United Nations Population Fund
- **Dr. Lauri Romanzi**, Project Director, Fistula Care *Plus*, EngenderHealth (moderator)

Side Event Title: Change Makers and Game Changers: Reimagining the Road to 2030

Date/Time/Venue: Tuesday, May 17 from 6:00pm to 9:00pm. B0-2, Bella Center

Overview: Ulla Muller, EngenderHealth's new President and CEO, will host a reception honoring EngenderHealth and our partners' work to advance SRHR globally.

Speakers

- **Digital pioneer and international crowdsourcing expert—Jacob Bøtter**
- **"Role Models for Change"—Ulla E. Müller, newly appointed President and CEO, EngenderHealth**
- **Heroes from the field—EngenderHealth partners**
- **Author and troublemaker—Jillian Reilly (moderator)**

APPENDIX D: FC+ STAFF AND PARTNER REPRESENTATION AT 2015 FIGO CONFERENCE IN VANCOUVER, BRITISH COLUMBIA

No.	Attendee	Origin
1	Nazmul Huda	Bangladesh
2	Christine Amisi	DRC
3	Adamu Isah	Nigeria
4	Habib Sadauki	Nigeria
5	Molly Tumusiime	Uganda
6	Simon Ndizeye	Uganda
7	Joseph Ruminjo	USA
8	Isaac Achwal	Kenya
9	Lauri Romanzi	USA
10	Michel Mpunga	DRC
11	Bethany Cole	USA

Title	Presenting author	FC+ Countries Represented
Oral Presentations		
Comparative risk of obstetric fistula and iatrogenic fistula from short height in Bangladesh	Nazmul Huda	Bangladesh
Pregnancy care utilization by female genital fistula clients in Bangladesh	Nazmul Huda	Bangladesh
The Panzi Classification and Score for female genital fistula	Christine Amisi	DRC
Community- based screening for OF in Nigeria: a novel approach to measurement and estimation	Adamu Isah	Nigeria
Responding to the risk of sexual and gender –based violence for abducted girls from Chibok, NorthEastern Nigeria	Adamu Isah	Nigeria
Can religious leaders act as conduits for OF prevention messages and for community mobilization?	Molly Tumusiime	Uganda
Maternal Health data management: strengthening use in resource-constrained health facilities in Western Uganda	Simon Ndizeye	Uganda
Translating RCT findings to practice: non inferiority of short duration catheterization after fistula repair	J Ruminjo	Global
Posters		
Increasing utilization of maternal health and FP services through community engagement approaches in rural Uganda	Simon Ndizeye	Uganda
Female genital fistula: clinical audit of complications from surgical treatment/ multi-country	Isaac Achwal	Global

APPENDIX E: SBCC FC+ OBJECTIVE 2 EXPERTS' WORKSHOP: AGENDA

Experts' Workshop | 11 – 12 February 2016
Elilly Hotel | Addis Ababa

TITLE

Fistula Care *Plus* Objective Two Experts' Workshop

GOAL

To share technical updates and strategize for technical interventions related to Objective Two across the global project

OBJECTIVES

By the end of the workshop, the participants will have:

- Discussed basic theory of behavior change
- Selected key behaviors related to project objectives
- Identified gaps in knowledge or activities related to key behaviors
- Exchanged experience (successes and specific lessons learned) from implementation of ongoing activities related to CE and SBCC within FC+ project)
- Identified next steps for development of country level action plans to be integrated into year four workplan

FC+ FRAMEWORK

Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia				
Obj. 1: Strengthened enabling environment to institutionalize fistula prevention, treatment, and reintegration in the public and private sectors	**Obj. 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula**	Obj. 3: Reduced transportation, communications, and financial barriers to accessing preventive care, detection, treatment, and reintegration support	Obj.4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment	Obj. 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation (M&E) indicators for prevention and treatment

1.1 Establish sustainability plans: from policy to implementation	**2.1 Create awareness and reduce stigma about OF**	3.1 Reduce transportation barriers for prevention and treatment of	4.1 Strengthen facility-level capacity to prevent fistula	5.1 Increase standardization in terminology, classification, and indicators
1.2 Improve data available on OF to facilitate planning	**2.2 Establish partnerships to facilitate achievable, holistic goals for reintegration to meet the needs of women with fistula**	3.2 Improve communication in support of fistula prevention, treatment, and reintegration	4.2 Increase capacity for treatment	5.2 Strengthen monitoring and evaluation/research (ME&R) systems and use of data
			4.3 Integrate family planning (FP) services to respond to client needs	5.3 Use research findings to improve practice
1.3 Advocate for a fistula-free generation		3.3 Reduce financial barriers to fistula prevention, treatment, and reintegration	4.4 Support and establish treatment/care programs for WDI and POP	5.4 Contribute to the evidence for improved programming and care

THURSDAY, 11 FEBRUARY 2016

Time	Session	Facilitator	Notes
8:30	Opening Session	Bethany Cole	Registration and introductions Workshop norms, procedures, and parking lot Workshop objectives and schedule Icebreaker
10:00	Reflections on SBCC Summit	Lauren Bellhouse	Participant reflections on summit and potential impact on our work
10:30	Break		
10:45	Case Identification in Kenya	Habiba Corodhia Mohamed	Guest speaker Habiba Corodhia Mohamed will discuss outreach activities of Fistula Foundation in Kenya
11:45	Introduction to Behavior Change: Our Roles and the Process of Planned Change	Elizabeth Arlotti-Parish	Terminology SBCC/BCC/SBC/IEC etc ; Relationship between CE and SBCC; Our roles in the process of behavior change; Determinants of behaviors
12:45	Lunch		Provided onsite
1:30	Thinking about Gender and Objective Two	Lauren Bellhouse	Discuss the different levels of gender messaging and EngenderHealth's aim for gender sensitive or transformative messaging

2:00	What does Behavior Change Mean in the Context of FC+?	Bethany Cole	Objective two activities in year three workplan
2:30	Counting Objective Two... and Making Objective Two Count	Vandana Tripathi	Review most recent DDM and indicators related to objective two and review project research related to objective two
3:00	Break		
3:30	Overview of the Designing for Behavior Change (DBC) Framework	Elizabeth Arlotti-Parish	Introduce framework for conceptualizing behaviors, priority groups, determinants of change, and linking activities to desired change. Within this session we will also discuss the work that is currently being done across the FC+ countries under objective two
5:00	Close		

Friday, 12 February 2016

Time	Session	Facilitator	Notes
9:00	Review Day One		
9:15	Selecting and Defining Behaviors	Elizabeth Arlotti-Parish	Group to provide comments, identify behaviors relevant to all countries, and priorities for each country. Examine which behaviors are easier/harder to change. Discuss definition of a behavior, components of behavior statements. Rewrite into behavior statements and finalize selection of 3-6 behaviors and write on DBC Framework flipcharts
10:30	Break		
11:00	Community Engagement and FC+	Blanka Homolova	Discussion on community engagement in the context of FC+ and challenges and priorities for establishing partnerships needed facilitate successful reintegration
12:30	WORKING LUNCH		Provided onsite; Group work on experience sharing related to community engagement
2:00	Report Out		Report out from working lunch
3:00	Break		
3:15	Year Four Workplan	Bethany Cole	Roles and responsibilities
4:30	Next Steps and Close	Bethany Cole	Timeline

APPENDIX F: SBCC FC+ OBJECTIVE 2 EXPERTS' WORKSHOP: PARTICIPANTS

APPENDIX G: ENGENDERHEALTH CLINICAL DATA FOR DECISION-MAKING MEETING: AGENDA AND PARTICIPANT LIST

Clinical Data for Decision-Making:
A Meeting to Improve Data Generation, Synthesis and Application

June 6 – 11, 2016
Addis Ababa, Ethiopia

AGENDA

Background:
In recent years, evidence-based decision-making and programming has become the expected standard in the field of sexual and reproductive health (SRH), as in most fields of medicine and public health. Quality evidence is essential for producing the best outcomes with limited resources, by allowing program managers and policy-makers to make decisions supported by good quality data rather than on instinct or intuition (or limited/poor quality data). EngenderHealth has increasingly invested resources to capture, synthesize and disseminate data, in order to support evidence-based decision-making. Currently, we collect an enormous amount of clinical data. However, like many organizations, we sometimes collect too much data, we don't always collect the right data and we don't always make optimal use of the data we have. In addition, between Ensuring Clinical Quality (ECQ) and monitoring, evaluation and research (ME&R) activities, there are redundancies among the data collected, including duplicate data collection processes. By improving the way that we generate and use clinical data, we will be better able to improve our program development; to ensure program success; and, to contribute to global learning both within EngenderHealth and among the global SRH community, generally.

We have convened this six-day meeting to improve the way in which we capture and use clinical data which relates to service delivery and the implementation of ECQ and QI interventions such as counseling, clinical training, clinical monitoring and coaching (CMC), COPE, facilitative supervision, whole-site-training. The meeting will contribute to the broad organizational initiative to improve data quality and use. In the lead up to the meeting, the Clinical Support team (CST) is updating the CMC Toolkit and the Clinical Training Toolkit that are used for ECQ activities. On a parallel track and in collaboration with the CST, the HQ Monitoring, Evaluation & Research (ME&R) team has completed an extensive review of tools used for program monitoring and evaluation across our programs and projects. Following that review, the teams have worked to develop template tools and guidance documentation, for use in the ME&R of our programs activities.

The meeting will bring together Senior Clinical and ME&R staff from EngenderHealth field programs as well as key HQ or other technical/programs staff. We aim to streamline data collection and improve clinical data usage through harmonization of tools and approaches used organization wide for ECQ and ME&R. In addition, we aim to facilitate greater and more effective cross-organizational learning and sharing.

Specific Objectives are:

1. To take stock of where we are and where we need and want to go with the data for decision-making process cross-organizationally
2. To foster greater accountability and ownership of organizational standards and practices, including in knowledge management, Monitoring & Evaluation, Research, and Clinical Support as well as for organizational metrics
3. To develop strategies to improve and strengthen data use cross-organizationally
4. To build capacity and to develop best practices for generating and using quality data
5. To develop strategies to improve and strengthen organizational learning
6. To develop project-level CDDM action plan and determine next steps (pathway to success)
7. To build capacity in technical writing
8. To ensure ownership of and compliance with key clinical SOPs (FP compliance and Mortality & Complications Reporting)
9. To build capacity in organization DHIS2 database & roll-up FY 2105-2016 data

DAY 1, MONDAY, JUNE 6TH **Objective 1—To take stock of where we are and where we need and want to go with data for decision-making process cross-organizationally**		
Time	**Activity/Presentation**	**Presenter**
8:00-8:30	Arrive in meeting room	
8:30-9:30	**Opening ceremony** • Welcome & introduction • Workshop rules of the road • Review of objectives, agenda and expected outcomes • Logistics	Levent, Caitlin, Carmela, and Nichelle
9:30-10:30	**The CDDM Initiative: Where we've been and where we are going**	Carmela
10:30-10:45	BREAK	
10:45-12:15	**The CDDM framework: Lightning presentations**	Moderator: Levent
12:15-13:30	**LUNCH**	
Energizer		Grace Viola
13:45-14:15	**Presentation of CDDM Guidance Document and Toolkit**	Caitlin

14:15-15:15	**Small group discussion of CDDM Guidance Document / Toolkit**	Moderator: Caitlin
15:15-15:30	**Comment on the next steps for the Guidance document and toolkit**	Mark
15:30-15:45	**BREAK**	
15:45-17:00	**Group work: Action planning for improving data use for decision-making**	Moderator: Carmela
17:00–17:30	**Wrap-up** (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Levent
17:30-18:30	Happy hour	

DAY 2, TUESDAY, JUNE 7TH
Objectives 2 & 3 —

- **To foster greater accountability and ownership of organizational standards and practices, including KM, MER, Clinical and organizational metrics**
- **To develop strategies to improve and strengthen data use**

Time	Activity/Presentation	Presenter
08:00–08:30	Arrive in meeting room	
08:30–09:00	Warm-up (Linking Day 1 to Day 2, energizer, housekeeping announcements)	Karen Leven
09:00-10:00	**EngenderHealth's KM & ME&R S&Ps**	Moderated: Caitlin
10:00-11:00	**EngenderHealth's Clinical S&Ps**	Moderated: Carmela
11:00-11:15	**BREAK**	
11:15-12:15	**Group work: Monitoring and Accountability for S&Ps**	Each group will be moderated by a member of the core team. Overall organizer for this session: Caitlin
12:15–13:15	**LUNCH**	
13:15–13:30	Energizer	Wondimu Tolera
13:30-15:00	**Doing More with Less: Improving the use of our clinical monitoring data**	Levent, Caitlin, and field staff

15:00–15:15	**BREAK**	
15:15-16:15	**Getting to Know EngenderHealth's Organizational Indicators**	Nichelle
16:15-16:30	**QUICK BRAINSTORM: What indicator is missing to measure our impact?**	Nichelle, Grace
16:30-17:15	**DHIS-what? How EngenderHealth is using DHIS2**	Nichelle, Karen Levin, Tesfaye and Edwin
17:15-17:30	**Wrap-up** (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Natasha

DAY 3, WEDNESDAY, JUNE 8TH **Objective 4 – To build capacity and to develop best practices for generating and using quality data**		
Time	**Activity/Presentation**	**Presenter**
09:00-09:15	**Warm-up** (Linking Day 2 & 3, energizer, house-keeping, announcements)	Leah
09:15-09:45	**What is clinical research and what does it take to do clinical research – best practices?**	Analee, Mark
09:45-10:15	**Review of clinical research capacities and opportunities**	Analee, Jared
10:15-11:00	**Group brainstorm around clinical research priorities**	Analee, Mark, and Jared
11:00-11:15	**BREAK**	
11:15-11:45	Introduction to best practices for DQA in SRH programming	Natasha, Mahabub
12:00-13:00	**LUNCH**	
13:15-13:30	ENERGIZER	Chrispin Mwizero
13:30-15:00	**EngenderHealth's Best practices for DQA** Lightning presentations on DQA process & moderated discussion for setting organizational best practices for DQA.	Moderators: Natasha, Mahabub

	(5 minutes per project – 9 presentations)	
14:45-15:00	**BREAK**	
15:00–16:00	**Activity: Tools for Data Visualization and Presentations**	Nichelle, field staff (to be identified)
16:00-17:00	**Monitoring and accountability for EngenderHealth's S&Ps** (half hour each; 15 minutes presentation; 15 minutes QA)	Caitlin, Carmela
17:00-17:15	**Wrap-up** (Brief overview of the day and link to the following day, daily evaluation and housekeeping announcements)	Quentin Awori
DAY 4, THURSDAY, JUNE 9TH **Objective 5 — To develop strategies to improve and strengthen organizational learning**		
Time	**Activity/Presentation**	**Presenter**
09:00–09:15	**Warm up** (Linking Day 4 to Days 1-3, energizer, housekeeping announcements)	Ringpon Gwamzhi
09:15–11:00	**Developing priorities for organizational learning:** • SRH service integration (Jared – with support from Sara M) • Quality improvement (Isaac/Colin) • Protecting, respecting and fulfilling client's rights (including potential clients) (Leah/Levent/Caitlin) • Moving from gender-sensitive to gender-transformative (TBD)	Main Moderators Sanjida, Caitlin Integration: Jared (support from Sara M) QI: Isaac, Colin, and Carmela Rights: Levent, Leah, and Caitlin (support from Elizabeth) Gender: Mandy Ackerman (support from Fabio)

11:00-11:15	**BREAK**	
11:15-12:15	**Innovations in SRH programs: EngenderHealth staff as changemakers**	Moderators: Caitlin, Analee, and Sanjida
12:15–13:30	**Be the Change: Fostering greater organizational learning**	Moderators: Caitlin, Analee, and Sanjida
	Wrap up (Preparation for tomorrow's action planning and handout commitment cards with instructions.)	n/a
13:30-14:30	**LUNCH**	
	AFTERNOON SOCIAL OUTING (OPTIONAL)	
DAY 5, FRIDAY, JUNE 10TH **Objective 6 – To develop CDDM action plan and determine next steps (pathway to success)**		
Time	**Activity/Presentation**	**Presenter**
08:30-9:00	Warm-up (Linking first four days, energizer, house-keeping, announcements)	Analee Etheredge
09:00-11:30	CDDM Action planning	Moderators: Levent, Grace
	BREAK (when need it during action planning)	
11:30-13:00	Action planning: peer review Each group will have 20 minutes to present to their peer and the peer will provide 25 minutes of feedback.	Moderators: one per peer group.
13:00-14:00	**LUNCH**	
14:00–14:15	Energizer	Rehema Kahando
14:15-16:30	**Getting to better CDDM: the path to success** GROUPWORK: What is needed for us to succeed in implementing our actions plans and further strengthening DDM at EngenderHealth? (14:15-15:30) PLENARY: Developing an organizational strategic plan for implementing successfully our vision.	Moderators: Levent, Mark
16:30-17:00	Closing remarks – inspiring better DDM!	Carmela
	BREAK when we need it	

17:00-17:30	Closing ceremony – certificates with CDDM commitments.	Levent, Nichelle

DAY 6, SATURDAY, JUNE 11TH
Objectives 7,8 & 9 –

- **To ensure ownership of and compliance with key clinical SOPs (FP compliance and Mortality & Complications Reporting)**
- **To build capacity in organization DHIS2 database & roll-up FY 2105-2016 data**

Time	Activity/Presentation	Presenter(s)
09:00—10:30	FP compliance, Complication and Mortality Reporting Protocols	FP compliance: Sanjida and Levent Mortality and complications: Carmela
10:30—11:00	DHIS2 Workshop – Orientation Exercise	Nichelle
11:00—11:15	**BREAK**	
11:15—12:30	DHIS2 Workshop –Practice Exercise	Nichelle
12:30—13:30	**LUNCH**	
13:30—15:30	DHIS2 Workshop –entering FY 14-15 data (cont'd)	Nichelle
15:30—15:45	**BREAK**	
15:45-16:30	DHIS2 Workshop –entering FY 14-15 data (cont'd)	Nichelle
16:30-17:00	Wrap up	Nichelle

Participant List

No.	Name	Position	Country	Project/Program
1	Hena Baroi	Program Officer, M&E	Bangladesh	FC+
2	Khandoker Abu Jafor Mohammad Saleh	Program Officer, Training and Service Delivery (IR 1) Team	Bangladesh	MH II
3	Md. Mahabub ul Anwar	Asia Regional ME&R Manager	Bangladesh	Regional MER
4	Md. Saiful Hasan	Program Officer, ME&R	Bangladesh	MH II
5	Sanjida Hasan	Project Manager	Bangladesh	MH II
6	Chrispin Mwizero	ME&R Officer	Burundi	BRAVI
7	Assefa Alem	Technical Director	Ethiopia	ABRI III
8	Daniel Asrat	Database & IT Officer	Ethiopia	ABRI III
9	Tesfaye Garedew	M&E Advisor	Ethiopia	ABRI III
10	Tibebeu Tucho	Clinical Advisor	Ethiopia	ABRI III
11	Wondimu Tolera	M&E Officer	Ethiopia	ABRI III
12	Zerihun Bogale	Training Advisor	Ethiopia	ABRI III
13	Sita Millimono	Clinical Advisor	Guinea	FC+

14	Anupama Arya	Chief Clinical Specialist	India	EAISI
15	Sasikala Kurumaddali	KM Advisor	India	EAISI
16	Sita Shankar Wunnava	Deputy Country Representative	India	EAISI
17	Isaac Achwal	Senior Clinical Associate and Coordinator	Kenya	Global CST
18	Jared Moguche Nyanchoka	Senior Clinical Advisor	Kenya	Global CST
19	Ominde Japheth Achola	Senior Clinical Advisor	Kenya	Global CST
20	Quentin Awori	Medical Associate	Kenya	Shang Ring
21	Aboubacar Garba Mai Birni	M&E Officer	Niger	FC+
22	Abiodun Amodu	Clinical Training Associate	Nigeria	FC+
23	Ringpon Joseph Gwamzhi	Data officer	Nigeria	FC+
24	Gerardito Cruz	MNCHN/FP Specialist	Philippines	Visayas Health
25	Grace Viola	Monitoring & Performance Management Specialist	Philippines	Visayas Health
26	Edwin Ernest	Senior Program Officer, ME&R	Tanzania	RTP
27	Leopold Tibyehabwa	Clinical Associate	Tanzania	RTP
28	Rehema Kahando	Field Office Manager	Tanzania	RTP
29	Levent Cagatay	Senior Clinical Advisor	Turkey	Global CST
30	Hassan Kanakulya	M&E Associate	Uganda	FC+
31	Paul Muwanguzi	Clinical Associate	Uganda	FC+
32	Ronald Luyera	Program Associate, M&E	Uganda	ExpandFP
33	Analee Etheredge	Technical Advisor, Research & Learning	USA/NY	Global MER
34	Caitlin Shannon	Director, Monitoring, Evaluation and Research/KM	USA/NY	Global MER
35	Carmela Cordero	Clinical Support Team Leader	USA/GA	Global CST
36	Colin Baynes	Manager, ME&R	USA/NY	PAC/FP
37	Karen Levin	Senior Program Associate	USA/NY	FC+
38	Leah Jarvis	Program Associate, ME&R	USA/NY	Global MER
39	Mark Barone	Senior Clinical Advisor	USA/NY	Global CST/MER
40	Natasha Lerner	Program Associate, ME&R	USA/NY	Global MER
41	Nichelle Walton	Program Associate, ME&R	USA/NY	Global MER
42	Amanda Ackerman	Senior Program Coordinator	USA/TX	US Programs

APPENDIX H: AGENDA FOR FC+ CLINICAL/M&E CHECK-IN

FISTULA CARE *PLUS*

M&E One-day Meeting| June 12, 2016

Location: Ezana Room at the Radisson Blu Hotel, Addis Ababa, Ethiopia

MEETING OBJECTIVE

- Update and Check-in for FC+ Clinical and M&E staff attending the EH CDDM meeting
  - FC+ DDM for Q2 in FY 15/16
  - Discussion of "new" and "old" indicators and data collection
  - DHIS2 check in
  - Inclusion of fistula indicators in in-country HMIS
  - Tracker/Checkers/Sentinel event implementation update

SUNDAY, 12 JUNE 2016

Time	Session	Details
9:00am	Welcome, introductions, and review of agenda and expectations	- Welcome - Introductions - Agenda overview
9:15am	Q2 FY15/16 DDM	Presentation and discussion of FC+ Q2 DDM
11:00am	Break	
11:15am	Discussion of new and old data indicators	- Objective 1 indicators - Objective 2 indicators - New clinical indicators (etiology, complexity, repair setting)
12:15pm	Data Collection and DHIS2 Check in	- Any issues? - Identification of refresher training topics/needed TA
12:45pm	Lunch	
1:45pm	Inclusion of fistula indicators in national HMIS	
2:15 pm	Track/Checkers/Sentinel Event reporting update	- Discussion of completed excel update form
3:00pm	Identification of concerns/needs	- Surgical training tools/follow up? - What else?
4: 30 pm	Summary/ Wrap Up	

APPENDIX I: NUMBER OF USAID-SUPPORTED FISTULA REPAIR SURGERIES BY COUNTRY, SITE AND YEAR

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**FY05-FY07**	**FY08-FY13**	**FY14-FY18**	**FY05-FY18**
Africa Mercy														
Benin	NS	NS	110	21	20	NS	NS	NS	NS	NS	NS	151	NS	151
Ghana	63	NS	NS	NS	NS	NS	NS	NS	NS	NS	63	NS	NS	63
Liberia	NS	59	NS	NS	NS	NS	NS	NS	NS	NS	NS	59	NS	59
Togo	NS	NS	NS	97	NS	NS	NS	NS	NS	NS	NS	97	NS	97
Total	**63**	**59**	**110**	**118**	**20**	**NS**	**NS**	**NS**	**NS**	NS	**63**	**307**	**NS**	**370**
Bangladesh														
Ad-Din Dhaka	NS	NS	NS	34	50	53	42	15	22	19	NS	179	56	235
Ad-Din Jessore	NS	NS	NS	2	1	25	48	0	21	0	NS	76	21	97
Ad-Din Khulna	NS	NS	NS	NS	NS	NS	NS	NS	37	6	NS	NS	43	43
BSMMU	NS	NS	NS	NS	NS	NS	NS	NS	18	30	NS	NS	48	48
Dr.Muttalib	NS	NS	NS	NS	NS	NS	NS	NS	30	26	NS	NS	56	56
Kumudini Hospital	53	57	49	37	25	33	48	26	85	28	53	249	139	441
LAMB Hospital	116	52	81	70	74	73	129	67	87	89	116	479	243	838
Mamm's Institute	NS	NS	NS	NS	NS	NS	NS	NS	70	75	NS	NS	145	145
Memorial Christian Hospital (MCH)	63	13	1	NS	NS	NS	NS	NS	NS	NS	63	14	NS	77
Total	**232**	**122**	**131**	**143**	**150**	**184**	**267**	**108**	**370**	**273**	**232**	**997**	**751**	**1980**
DRC														

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**FY05-FY07**	**FY08-FY13**	**FY14-FY18**	**FY05-FY18**
HEAL Africa Hospital	268	200	214	210	163	288	264	NS	44	183	268	1339	227	1,834
Imagerie Des Grands-Lacs	NS	NS	NS	NS	38	78	89	NS	40	127	NS	205	167	372
Maternité Esengo de Kisenso	NS	NS	NS	NS	NS	NS	27	NS	NS	NS	NS	27	NS	27
Maternite Sans Risque Kindu	NS	NS	NS	NS	35	151	82	NS	68	226	NS	268	294	562
Mutombo	NS	NS	NS	NS	104	80	119	NS	NS	NS	NS	303	NS	303
Panzi Hospital	371	134	268	262	180	500	567	NS	105	223	371	1911	328	2,610
St. Joseph	NS	NS	NS	NS	45	124	208	NS	128	241	NS	377	369	746
DRC Bilaterals														
Project AXxes	NS	361	442	514	NS	NS	NS	NS	NS	NS	NS	1317	NS	1,317
PS Kabongo	NS	NS	NS	NS	NS	50	NS	NS	NS	NS	NS	50	NA	50
PS Katako Kombe	NS	NS	NS	NS	NS	87	NS	NS	NS	NS	NS	87	NA	87
PS HGR Katana	NS	NS	NS	NS	NS	NS	50	NS	NS	NS	NS	50	NA	50
PS Kaziba	NS	NS	NS	NS	NS	152	135	60	158	240	NS	287	458	745
PS Lodja	NS	NS	NS	NS	NS	82	NS	NS	NS	NS	NS	82	NS	82
PS Luiza	NS	NS	NS	NS	NS	28	NS	NS	NS	NS	NS	28	NS	28
PS Malemba Kulu	NS	NS	NS	NS	NS	60	NS	NS	NS	NS	NS	60	NS	60
PS Tshikaji	NS	NS	NS	NS	NS	49	NS	NS	NS	NS	NS	49	NS	49
PS Uvira	NS	NS	NS	NS	NS	13	37	NS	NS	NS	NS	50	NS	50
Total	**639**	**695**	**924**	**986**	**565**	**1742**	**1,578**	**60**	**543**	**1240**	**639**	**6490**	**1,843**	**8,972**
Ethiopia														
Arba Minch Hospital	NS	NS	NS	27	NS	NS	NS	NS	NS	NS	NS	27	NA	27
Bahir Dar Fistula Center	564	596	297	383	307	392	NS	NS	NS	NS	564	1975	NA	2,539

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**FY05-FY07**	**FY08-FY13**	**FY14-FY18**	**FY05-FY18**
Mekelle Center	NS	NA	166	177	195	198	NS	NS	NS	NS	NS	736	NA	736
Total	**564**	**596**	**463**	**587**	**502**	**590**	**NS**	NS	NS	NS	**564**	**2,738**	**NA**	**3,302**
Guinea														
Ignace Deen	193	63	49	20	NS	NS	0	NS	NA	NA	193	132	NS	325
Jean Paul II	NS	36	88	126	144	185	90	NS	NA	NA	NS	669	NS	669
Kissidougou	298	130	148	132	193	189	173	NS	15	49	298	965	64	1327
Labe	NS	NS	31	114	122	123	132	NS	5	16	NS	522	21	543
Mercy Ships training repairs	NS	NS	NS	NS	NS	NS	25	NS	NS	NS	NS	25	NS	25
Total	**491**	**229**	**316**	**392**	**459**	**497**	**420**	**NS**	**20**	**65**	**491**	**2,313**	**85**	**2,889**
Mali														
Gao Regional Hospital	NS	NS	46	40	91	53	NS	NS	NS	NS	NS	230	NA	230
Kayes Hospital	NS	NS	NS	NS	NS	NS	70	NS	NS	NS	NS	70	NA	70
Mopti	NS	NS	NS	NS	NS	NS	20	NS	NS	NS	NS	20	NA	20
Sikasso	NS	NS	NS	NS	NS	NS	140	NS	NS	NS	NS	140	NA	140
Mali Bilateral														
IntraHealth	NS	NS	NS	NS	NS	NS	NS	47	381	244	NS	NS	672	672
Total	**NS**	**NS**	**46**	**40**	**91**	**53**	**230**	**47**	**381**	**244**	**NS**	**460**	**672**	**1,132**
Niger														
Dosso Regional Hospital	NS	17	15	22	41	21	13	NS	NS	NS	NS	129	NS	129
Lamorde Hospital (Niamey)	27	70	84	129	173	110	92	NS	NS	NS	27	658	NS	685
Maradi Regional Hospital (now CSME Maradi)	NS	123	59	63	67	45	65	0	55	9	NS	422	64	486
National Maternity Center, Niamey	NS	NS	NS	NS	NS	NS	80	NS	NS	NS	NS	80	NS	80

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**FY05-FY07**	**FY08-FY13**	**FY14-FY18**	**FY05-FY18**
National Obstetric Fistula Center, Niamey (now CNRFO)	NS	NS	NS	NS	NS	NS	NS	105	144	245	NS	NS	494	494
Tahoua (now CSME Tahoua)	NS	NS	NS	6	52	33	44	22	28	54	NS	135	104	239
Tera District Hospital	NS	3	NS	NS	NS	NS	NS	NS	NS	NS	NS	3	NS	3
Zinder	NS	NS	NS	NS	NS	NS	79	NS	NS	NS	NS	79	NS	79
Total	**27**	**213**	**158**	**220**	**333**	**209**	**373**	**127**	**227**	**308**	**27**	**1,506**	**662**	**2,195**
Nigeria														
National Obstetric Fistula Centre Abakaliki	NS	NS	189	330	268	277	316	71	283	134	NS	1,380	488	1,868
Babbar Ruga Hospital (Katsina)	356	536	331	359	330	416	359	160	309	244	356	2,331	713	3,400
Faridat Yakubu General Hospital (Zamfara)	180	150	187	115	114	116	126	21	49	95	180	808	165	1,153
General Hospital Ogoja (Cross River State)	NS	NS	NS	NS	NS	114	50	14	17	17	NS	164	48	212
UTH Ibadan	NS	NS	NS	NS	NS	NS	37	18	6	6	NS	37	30	67
Gesse VVF Center (Kebbi)	102	122	151	207	216	215	152	55	140	171	102	1,063	366	1,531
Laure Fistula Center at Murtala Mohammed Specialist Hospital (Kano)	339	473	337	265	379	288	313	122	386	270	339	2,055	778	3,172
Maryam Abacha Women's and Children's Hospital (Sokoto)	104	156	152	200	137	138	132	93	183	103	104	915	379	1,398
Ningi General Hospital (Bauchi)	NS	NS	NS	NS	63	78	74	NS	131	164	NS	215	295	510
Other	NS	NS	NS	136	NS	43	NS	NS	NS	20	NS	179	20	199
Adeoyo GH	NS	NS	NS	NS	NS	NS	NS	NS	18	18	NS	NS	36	36
Jahun VVF Center	NS	NS	NS	NS	NS	NS	NS	NS	79	204	NS	NS	283	283
Sobi General Hospital (Kwara State)	NS	NS	NS	NS	NS	35	21	NS	44	13	NS	56	57	113
Family Life VVF Center	NS	NS	NS	NS	NS	NS	NS	NS	NS	52	NS	NS	52	52
Hajiya Gambo Sawaba VVF Center	NS	NS	NS	NS	NS	NS	NS	NS	NS	72	NS	NS	72	72

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**FY05-FY07**	**FY08-FY13**	**FY14-FY18**	**FY05-FY18**
Evangel VVF Centre, Jos, Plateau State	NS	NS	NS	NS	NS	NS	NS	NS	NS	0	0	0	0	0
Total	**1,081**	**1,437**	**1,347**	**1,612**	**1,507**	**1,720**	**1,580**	**554**	**1645**	**1583**	**1,081**	**9,203**	**3,782**	**14,066**
Rwanda														
CHUK	100	36	51	126	109	4	9	NS	NS	NS	100	335	NS	435
Kanombe Hospital	NS	NS	14	48	38	55	35	NS	NS	NS	NS	190	NS	190
Kibogora	NS	NS	NS	NS	NS	21	0	NS	NS	NS	NS	21	NS	21
Ruhengeri	192	47	102	85	131	34	4	NS	NS	NS	192	403	NS	595
Total	**292**	**83**	**167**	**259**	**278**	**114**	**48**	**NS**	**NS**	**NS**	**292**	**949**	**NS**	**1,241**
Sierra Leone														
Aberdeen	272	363	253	166	211	244	115	NS	NS	NS	272	1,352	NS	1,624
Total	**272**	**363**	**253**	**166**	**211**	**244**	**115**	**NS**	**NS**	**NS**	**272**	**1,352**	**NS**	**1,624**
Tanzania														
Vodafone/CCBRT	NS	NS	NS	NS	NS	NS	NS	705	828	1048	NS	NS	2581	**2,581**
Total	**NS**	**NS**	**NS**	**NS**	**NS**	**NS**	**NS**	**705**	**828**	**1048**	**NS**	**NS**	**2,581**	**2,581**
Uganda														
Hoima RRH	NS	NS	NS	NS	NS	184	102	63	49	40	NS	286	152	438
Kagando / Bwera	253	118	85	206	363	143	237	NS	NS	NS	253	1152	NS	1405
Kitovu Mission Hospital / Masaka	604	192	183	243	248	190	183	NS	200	204	604	1239	404	2247
Kamuli Mission Hospital	NS	NS	NS	NS	NS	NS	NS	NS	NS	63	NS	NS	63	63
Jinja RRH	NS	NS	NS	NS	NS	NS	NS	NS	NS	43	NS	NS	43	43
Total	**857**	**310**	**268**	**449**	**611**	**517**	**522**	**63**	**249**	**350**	**857**	**2,677**	**662**	**4,196**

	Pre-FC	Fistula Care						Fistula Care Plus			TOTALS			
	FY05-FY07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Pre-FC	FC Total	FC+ Total	Grand Total
Country/Site	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	FY05-FY07	FY08-FY13	FY14-FY18	FY05-FY18
Overall Total	4,518	4,107	4,183	4,972	4,727	5,870	5,133	1,664	4,263	5,111	4,518	28,992	11,038	44,548
EngenderHealth Supported	3,954	3,150	3,278	3,871	4,225	4,759	4,911	852	2,896	3,579	3,954	24,194	7,327	35,475
EH Non-USAID Supported	NS	NS	NS	NS	NS	NS	NS	NS	20	NS	NS	NS	20	20
EH USAID Supported	3,954	3,150	3,278	3,871	4,225	4,759	4,911	852	2,876	3,514	3,954	24,194	7,242	35,390
USAID Bilaterals	564	957	905	1,101	502	1,111	222	812	1,367	1597	564	4,798	3,776	9,138
Total USAID-Supported	4,518	4,107	4,183	4,972	4,727	5,870	5,133	1,664	4,243	5,111	4,518	28,992	11,018	44,528

NA= Data not available NS= Site not supported

APPENDIX J: SUMMARY TABLE FROM LANDSCAPE REVIEW OF NATIONAL STRATEGIES FOR OBSTETRIC FISTULA PREVENTION AND TREATMENT

Countries Supported by Fistula Care *Plus*												
Country	**Year**	**Family planning**	**Addresses reintegration**	**Addresses women deemed incurable**	**Secures budget line item**	**Iatrogenic**	**HMIS**	**Traumatic fistula**	**TA from FC/FC+**	**Integrated fistula into national policies**	**Prevention approach**	**Community engagement- (P)revention/ (T)reatment/ (R)eintegration**
Uganda	2010/11-2014/15	✓	✓	No	No*	No	✓	No	✓	✓	✓	T, R
Bangladesh	2013-2016	✓	✓	✓- limited	No*	✓	✓	No	✓	✓	✓	P, T, R
DRC	2007-2009	✓	✓	✓	No*	No	No	✓	No	✓	✓	P, T, R
Guinea	2012-2016	✓- limited	✓	✓- limited	No*	No	✓	✓	✓	✓	✓	P, R
Niger	2015-2019	✓	✓	✓	✓	No	✓	No	✓	✓	✓	P
Nigeria	2011-2015	✓	✓	No	No*	No	✓	No	✓	✓	✓	P, R
Other												
Rwanda	2009	✓	✓	No	No*	No	✓	✓	✓	✓	✓	P
Mali	2009	No	✓	No	No*	✓	✓	No	✓	No	✓	P,R
Mauritania	2005-2006	✓	✓	No	✓	No	✓	No	No	✓	✓	P,R
Burkina Faso	2005-2006	✓	✓	✓	✓	✓	✓*	No	No	✓	✓	P,R

APPENDIX K: FC+ GENDER ACTION PLAN

I. Introduction

Disparities exist between men and women across social, political, and economic spheres, leading to gender inequalities that undermine the wellbeing all persons.[24] High maternal and child mortality, early and forced marriage, sexual and gender based violence, and harmful traditional practices remain pervasive forms of gender inequalities globally, particularly in lower and middle income countries.[25] Detrimental gender norms and attitudes, as well as rigidly-defined gender roles, have a profound effect on the health of all persons, especially women and children. Research has shown that women's limited decision making power and financial autonomy has had negative effects on outcomes related to sexual and reproductive health (SRH) and maternal, newborn, and child health (MNCH).[26] Gender inequalities continue to limit opportunities available to women and girls, particularly related to their access to health services.

Under its **Gender Equality and Female Empowerment Policy**, USAID invests in efforts to achieve three overarching outcomes:

1. Reduce gender disparities in access to, control over, and benefits from resources, wealth, opportunities, and services¬—economic, social, political, and cultural.
2. Reduce gender-based violence and mitigate its harmful effects on individuals.
3. Increase capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making in households, communities, and societies.[27]

The Fistula Care *Plus* (FC+) project aims to deliberately address gender inequalities in order to maximize its overall impact. **Gender integration** is the process of applying a gender strategy to program design, implementation, and evaluation. Through the integration of gender, the FC+ project aims to address underlying causes of fistula that are linked to gender inequality and respond to negative gender attitudes and norms that result in barriers to women's access to key health services, such as maternal health care, family planning, and timely access to emergency obstetric care.[28] Addressing harmful gender attitudes and norms will also help to reduce stigma and increase community support for the successful social reintegration of fistula clients. By integrating gender issues into program implementation, FC+ can not only improve women's access to health services, but also contribute to the promotion of women's empowerment, which offers benefits to men, children, and communities at large.

[24] IPPF Africa Region. What We Do: Gender equality. Available at: http://www.ippfar.org/our-work/what-we-do/gender-equality

[25] Ibid (IFFP).

[26] USAID and IGWG. Gender Perspectives Improve Reproductive Health Outcomes: New Evidence. Available at: http://www.igwg.org/igwg_media/genderperspectives.pdf

[27] USAID Office of Gender Equality and Women's Empowerment Website. August, 2016. Available at: https://www.usaid.gov/who-we-are/organization/bureaus/bureau-economic-growth-education-and-environment/office-gender

[28] Population Reference Bureau. Pursuing Gender Equality Inside and Out: Gender mainstreaming in international development organizations. 2015. Available at: http://www.prb.org/pdf15/gender-mainstreaming.pdf

Addressing genital fistula, by nature, is a response to gender inequality. Genital fistula results from a lack of attention and allocation of resources to the basic and emergency needs of women and girls. Core manifestations of gender inequality that often lead to fistula include: low health literacy; poor nutrition; gender disparities in educational opportunities; early marriage; limited agency for deciding care-seeking behaviors; lack of access to family planning or maternal, newborn, and child health (MNCH) services, including emergency obstetric care; low quality of care once service is attained. In addition to these challenges, women also experience sexual and gender-based violence (SGBV), often aggravated in areas of conflict, that can result in traumatic fistula. Underlying and structural gender inequality must be addressed, alongside availability and quality of clinical services, if we truly hope to see a generation free of fistula.

II. Background of FC+ Gender-Related Work

The international field of genital fistula and the Fistula Care Plus project provide a continuum of care throughout a woman's lifespan. Under the previous Fistula Care project, much effort was spent establishing or strengthening existing treatment services, increasing awareness at the policy, community, and individual levels of the causes of fistula, as well as addressing myths and misunderstandings. Gender was integrated into specific activities, largely around facility-based care and provider capacity. For example, *Counseling the Obstetric Fistula Client: A Training Curriculum* and its accompanying *Counseling the Traumatic Fistula Client: A Supplement to the Obstetric Fistula Counseling Curriculum* were both developed with a strong gender lens and with input from gender experts.

Under FC+, two countries (West Africa/Niger and Nigeria) included plans to address early marriage in their Year Two workplans. Building on this, two countries (Nigeria and Uganda) included activities to engage men as partners in Year Three workplans. In Nigeria, a sixth objective has been added to the PMP, at the request of the USAID Mission in response to regional instability, to address the specific health needs of survivors of SGBV. With assistance from the EngenderHealth Gender team, the project developed and shared a toolkit for addressing the medical needs of abducted girls and women in northern Nigeria. This toolkit can be utilized by providers and partners working with SGBV survivors more broadly across the nation.

In addition to the specific gender-focused activities listed below, all FC+ country programs must ensure that their programming, including community volunteer curriculum and social and behavior change (SBC) materials, adhere to the principles of gender equality. These include:

- Choosing programmatic and research partners who adhere to practices and policies in line with a gender sensitive or transformative approach;
- Ensuring organizational practices, including but not limited to budgeting, recruitment and HR, and decision making, that are gender sensitive and advance equality;
- Recognizing gender equality as a human right;
- Seeking to involve men and boys as key allies while not jeopardizing the sexual and reproductive health and rights (SRHR) or agency of women;
- Including local and international women's rights stakeholders in the design and implementation of program activities where possible.

- Ensuring that programs integrate gender, where possible, and utilize gender sensitive or gender transformative messaging across activities.
- **Gender sensitive approaches** *acknowledge the role of gender norms and inequalities and seeks to develop actions that compensate for them. These projects do not seek to change norms, but do attempt to limit their harmful impact.*
- **Gender transformative approaches** *are programs and interventions that create opportunities for individuals to actively challenge negative gender norms, promote positions of social and political influence for women in communities, and address gendered power inequities.*[29]

Figure 1 The continuum of gender programming (adapted from Geeta Rao Gupta SIECUS Report

Gender transformative approaches create an enabling environment for change by going beyond including women as participants to affect gendered power dynamics that serve as barriers to an individual's decision making ability about his/her health. For women, this can include, but is not limited to, access and uptake of family planning, birth spacing, access to maternity and safe delivery services, and ability to seek fistula treatment services. For men, this often includes how cultural ideals around masculinity influence health seeking behavior. While both men and women are negatively affected by structural gender inequality, women and girls are often disproportionately affected, especially in societies with traditional and restrictive gender norms. FC+ will ensure that all programming is at least gender sensitive, and will strive to implement gender transformative approaches when feasible.

III. Recommended Actions for Immediate Gender Integration

A Gender Focal Point has been established for the FC+ project, Lauren Bellhouse (FC+ Program Associate). The Gender Focal Point, with input from the FC+ Global Team and technical advisors from the EngenderHealth Gender team, has developed this Gender Action Plan to address the training, capacity, and programmatic needs of the project in its entirety and ensure that it integrates gender where possible. This action plan is based on input from country programs through key informant interviews and feedback shared by country teams during gender-focused workshops, as well as best practices related to gender equitable programing and recommendations from the Gender team (see figure 1).

The key recommendations for the Gender Action Plan fall into three categories: 1) building the capacity of FC+ staff on gender-related issues, 2) ensuring gender sensitive or transformative activities across the program, in line with EngenderHealth Gender S&Ps, and 3) engaging men as partners and agents of change in the prevention and treatment of fistula.

[29] HC3. Gender Transformative Approaches an HC3 Research Primer. Available at: http://www.healthcommcapacity.org/wp-content/uploads/2014/08/Gender-Transformative-Approaches-An-HC3-Research-Primer.pdf

1. Build capacity of all program staff to be able to design and implement gender sensitive or gender transformative activities

a. Conduct country level Gender 101 trainings and follow-up workshops

- Conduct Gender 101 trainings in all FC+ supported countries for all FC+ staff and, where feasible, staff of subaward partner organizations. The objectives of the Gender 101 workshop are:
    i. To improve understanding of the differences between gender, sex, and sexuality;
    ii. To identify harmful gender norms, roles and attitudes that affect SRH negatively;
    iii. To understand the characteristics of gender sensitive and gender transformative programs;
    iv. To understand the connection between gendered power dynamics and violence and to recognize the links between gender, power, and access to services.

These workshops should also allow FC+ staff to identify specific actions to improve gender sensitivity of project activities within their country context. For example, FC+ staff should support activities that identify and respond to gender-related barriers that impede programmatic successes in order for the project to be more gender-responsive. Pre- and post- test questionnaires will be administered at all Gender 101 trainings and the outcomes of the training will be documented and shared with FC+ leadership. Number of staff and partners trained will also be reported on in the semi-annual and annual reporting to USAID.

As of June 2016, staff from the country programs in Bangladesh (15), West Africa/Niger (5), Nigeria (30), and representatives from DRC sub-award sites (3) have received Gender 101 training by the FC+ Gender Focal Person, Lauren Bellhouse, and EngenderHealth's Senior Associate for Gender, Maimouna Toliver.

- From workshops, each country program develops an action plan that is monitored and updated. This may include approving proposed gender activities that can start during the current program year, as well as identifying activities that should be included in the next year's workplan and budget.
- Establish the FC+ Program Associate as the Gender Focal Person to lead and monitor gender efforts for all FC+ countries, as well as for the FC+ global team at HQ level. The Gender Focal Person will ensure continued collaboration between FC+ and the EngenderHealth Gender team on technical assistance provided to FC+ country teams.
- When possible, the FC+ Gender Focal Person will work with FC+ staff who have received the Gender 101 training to conduct smaller, targeted presentations on gender for EngenderHealth colleagues and partner organization staff. This will help to reinforce gender knowledge and attitudes in FC+ staff while promoting gender equality as an important component of EngenderHealth programming. The EngenderHealth Gender team will be notified and consulted when these step-down presentations are taking place.
- Training of trainers (TOT) will be conducted with select project staff as requested. The Gender Focal Point and the EngenderHealth Gender team will be engaged in the TOTs.
- Establish Gender Working Groups in country program offices where possible. These working groups are reflecting of the needs within the country office, and may focus on internal and/or wider, programmatic gender issues. As of the last quarter of year three, Bangladesh and Nigeria country offices have formed Gender Working Groups.

- Conduct bi-annually or yearly reflective sessions for staff on gender issues from the project, and/or identify opportunities to include personal reflection on gender in ongoing/routine project activities (i.e., annual work planning meetings).

b. Build the knowledge base around gender equality across program implementation countries

- Conduct a gender-focused landscape review for each of the FC+ countries, and use the findings to inform the inclusion of gender-responsive activities and gender-sensitization trainings moving forward.
- Where appropriate, conduct community and/or provider KAPB assessments on gender, and use the findings to inform the inclusion of gender-responsive activities and gender-sensitization trainings moving forward.
- Research evidence-based program approaches for engaging men as partners in SRH and fistula care and prevention.

Activity	Completed	Ongoing	Y2	Y3	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Conduct gender 101 trainings in all country programs		X	X	X		X						
Develop and carry out country-specific gender action plans		X		X	X	X	X	X	X			
Establish Lauren Bellhouse as Gender Focal Point	X			X								
Trained staff will conduct gender presentations and step-down trainings as needed					X	X	X	X	X			
Conduct TOTs with FC+ staff and partners as requested					X	X	X					
Establish Gender Working Groups in country offices where possible (currently in Nigeria and Bangladesh)	X		X	X								
Hold bi-annual or yearly reflective sessions on gender with oriented staff					X		X		X		X	
Carry out gender-focused landscape review		X		X	X	X						
Conduct community and/or provider KAPB assessments where feasible on gender to inform activities and trainings					X	X	X	X				

Research evidence-based approaches for engaging MAP in SRH		X	X	X	X	X						

2. Ensure program activities and materials, including SBCC and IEC materials, are gender sensitive or gender transformative.

- Focus on moving from straightforward community engagement activities to gender transformative activities when feasible. If possible, women from the target communities should be involved in the planning or pre-testing of activities and SBCC/IEC materials.
- Review all project SBCC and IEC materials, community health worker curriculums, and facility level training curriculums to ensure that they do not portray any negative gender values or stereotypes and are, at the least, gender sensitive in their approach. Where feasible, IEC materials can integrate language into messaging around empowering women and girls and eliminating harmful gender norms. A committee of headquarters and country program staff will review these materials. The committee will consist of: gender, community engagement, and SBCC technical experts at EngenderHealth headquarters; the FC+ Gender Focal Point; the Objective 2 Working Group, a group of SBCC and community engagement experts.
- Engage community-based, national-level, and international gender equality stakeholders as partners when feasible during the design, implementation, and monitoring of program activities. In Uganda, partner organization TERREWODE is working to support community engagement on gender, reintegration of women with fistula, stigma reduction, and support for women whose fistulas are deemed incurable and those whose fistulas are the result of sexual violence. Ultimately, TERREWODE will be able to provide south-south support for these issues.
- Continue to support West Africa/Niger, Nigeria, DRC, and Uganda programs to address the issue of early marriage and childbirth at a national and sub-national policy level.

Activity	**Completed**	**Ongoing**	**Y2**	**Y3**	**Y4 Q1**	**Y4 Q2**	**Y4 Q3**	**Y4 Q4**	**Y5 Q1**	**Y5 Q2**	**Y5 Q3**	**Y5 Q4**
Move from straightforward community engagement activities to gender transformative activities when feasible		X		X	X	X	X	X	X	X		
Engage women from target communities in IEC materials pretesting				X								
Review all project SBCC and IEC materials, community health worker curriculums, and facility level training curriculums		X		X	X	X	X	X				
Engage community-based, national-level, and international gender equality stakeholders as program partners		X	X	X	X	X	X	X	X	X	X	X
Support policy discussions on early and forced marriage		X	X	X	X	X	X	X	X			

3. Engage men and boys as allies and change agents for the prevention and treatment of fistula

- FC+ will seek to actively engage men and boys as allies in promoting sexual, reproductive, and maternal health, including the prevention and treatment of fistula, as well as in preventing and responding to SGBV. FC+ will aim to do this while not detracting from the agency of female clients. As much as possible, country programs should seek to engage members of the target communities, including traditional and religious leaders, in the development and implementation of men as partners (MAP) activities.
- The project will document and disseminate stories of fistula champions (male, female, and couples) who have fought against stigmatization of fistula clients and worked to change harmful gender norms.

Activity	Completed	Ongoing	Y2	Y3	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Engage men and boys (including traditional and religious leaders) as allies in promoting SRH and maternal health while not detracting from the agency of female clients		X	X	X	X	X	X	X	X	X		
Document and disseminate stories of fistula champions (male, female, and couples)		X		X	X	X	X	X	X	X		

IV. Recommended Resources

- USAID→ Gender Equality and Female Empowerment Policy 2012
- Measure Evaluation→ Gender sensitivity in the service deliver environment.
- CARE→ Gender Toolkit
- UNFPA→ Gender at the Heart of ICPD: The UNFPA Strategic Framework on Gender Mainstreaming and Women's Empowerment.
- HC3→ Gender Transformative Approaches: An HC3 Research Primer
- EngenderHealth→ Engaging Men at the Community Level.
- Global Health eLearning Center→ Gender and Health Systems Strengthening E-Course
- Health Policy Project→ Brief Series: Transforming gender norms, roles, and dynamics for better health

APPENDIX L: CAUSAL PATHWAY FOR FC+ POP INTEGRATION WORK[30]

FC+ POP Integration - Logic Model V4 March 1, 2016

Notes:

- *Shaded activities are occurring "independently" of FC+ POP integration activities, but are important for success.*
- *Red text denotes an item about which there is continuing discussion.*

Inputs	**Activities/Processes**	**Outputs**	**Outcomes (Short-term/intermediate)**	**Impacts (Long-term)**
- FC+ budget resources 2016-2018 - Facilities with interest in POP integration and adequate human resources resources/infrastructure capacity to provide POP/fistula services and absorb technical assistance - USAID support (Washington/country) - MOH support - Human resources for training, M&E, and administrative support (FC+, consultants, facility)	- Procure surgical and non-surgical equipment and supplies as needed, including pessaries - Finalize global prolapse integration training manual and curricula for site-level trainings and secure technical endorsement (FIGO/RCOG) - Conduct comprehensive site assessments for POP & fistula, including clinical capacity, tracking systems, patient volume, and payer models/revenue channels - Conduct whole-site planning for POP integration, including:	- POP service equipment and supplies available at facilities - Global training manual and curricula finalized - Global training manual & curricula endorsed by partners (FIGO/RCOG) - Site assessments completed and synthesized - Site-specific POP integration plans (including patient care protocols) finalized and endorsed by facility in-charges	- Increased capacity to provide POP evaluation & management according to minimum int'l standards at pilot POP integration facilities by 2018 - Increased proportion of POP and fistula clients receiving adequate treatment at pilot POP integration facilities by March 2018	- Decreased disability from POP and fistula among women in low-resource countries

[30] Pilot implementation details are subject to change based on site-specific needs, consultant availability, and external factors (e.g., political instability)

Inputs	Activities/Processes	Outputs	Outcomes (Short-term/intermediate)	Impacts (Long-term)
- Draft clinical training curricula - Draft M&E tools, including proposed indicators, site assessment tool, client tracker, and skills tracker - Advocacy partners (e.g., ACOG global) for facilitating pessary PPP and endorsement of training materials - Suppliers for pessaries and other required equipment/supplies	a) Engagement of key stakeholders at site launch meeting b) Development of site-specific patient care protocols for integration of POP & fistula c) Finalization of site-specific training curricula - Conduct relevant didactic & hands-on competency-based trainings for clinicians on surgical & nonsurgical POP & fistula services at each site, including: a) Evaluation of POP & fistula cases (midwives, nurses, physicians) b) Non-surgical mgmt of POP & Fistula (midwives, nurses, physicians) c) Surgical mgmt of POP (surgeons & anesthetists) d) Peri-op mgmt POP & fistula (nurses & midwives, surgeons & anesthetists) e) Whole-site orientation on patient care protocols - Ensure adoption of shared measurement system (POP &	- Clinicians and other facility staff assessed as competent in POP & fistula services post-training and at follow-up observations - Follow-up clinical visits conducted with adequate frequency/scopes of work - Patients receiving timely, reliable POP & fistula services at facilities - Sites reporting timely and complete data using shared measurement system - Sustainability plan completed at each facility, including projected financing of POP & fistula services post-FC+ - PPPs for pessary procurement established with MOH commitment/endorsement	- Increased financial & human resources sustainability (e.g., retention) of fistula treatment services at pilot facilities by March 2018	

Inputs	Activities/Processes	Outputs	Outcomes (Short-term/intermediate)	Impacts (Long-term)
	fistula client tracker, skills acquisition tracker) - Conduct follow-up clinical support visits (including interval site assessment, clinical refresher training, observation of care, and DDM/review of skills & client data) - Develop site-specific post-FC+ sustainability plan - Facilities continue to provide routine and/or reliable POP and fistula evaluation and management services - FC+ develops PPP with pessary supplier (including MOUs with supporting advocacy partners, e.g., FIGO/RCOG/ACOG)			

APPENDIX M: FC+ ANNUAL PARTOGRAPH MONITORING: FY 14/15

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	Maximum = 5	Maximum = 100%
Bangladesh	**175**	**0.45**	**n/a**	**0.41**	**0.41**	**0.41**	**0.38**	**0.10**	**0.10**	**2.05**	**100.00%**
LAMB	25	1.00	n/a	0.88	0.88	0.88	0.88	0.04	0.04	4.52	100.00%
Ad-din Dhaka	25	1.00	n/a	0.84	0.84	0.84	0.84	0.00	0.00	4.36	n/a
Ad-din Jessore	25	0.32	n/a	0.32	0.32	0.32	0.28	0.32	0.32	1.56	100.00%
Ad-din Khulna	25	0.32	n/a	0.32	0.32	0.32	0.24	0.32	0.32	1.52	100.00%
BSMMU	25	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Kumudini	25	0.48	n/a	0.48	0.48	0.48	0.44	0.04	0.04	2.36	100.00%
Muttalib	25	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Niger	**50**	**1.00**	**0.70**	**0.88**	**1.00**	**1.00**	**1.00**	**0.00**	**0.00**	**4.88**	**n/a**
CSME Maradi	25	1.00	0.92	0.76	1.00	1.00	1.00	0.00	0.00	4.76	n/a
CSME Tahoua	25	1.00	0.48	1.00	1.00	1.00	1.00	0.00	0.00	5.00	n/a
Nigeria	**276**	**0.17**	**0.00**	**0.00**	**0.01**	**0.00**	**0.00**	**0.00**	**0.00**	**0.18**	**0.00%**

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	Maximum = 5	Maximum = 100%
Takai Clinic, Kano	23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Kumbotso, Kano	23	1.00	n/a	0.04	0.13	0.00	0.00	0.04	0.00	1.17	0.00%
Maryam Abatcha, Kano	23	1.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	1.00	n/a
Ungwa Uku, Kano	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Miga, Jigawa	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Aujara, Jahun, Jigawa	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Dutse, Jigawa	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Gwaram Cottage, Jigawa	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
GH Ningi, Bauchi	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Low Cost PHC, Bauchi	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Warji Town Mat, Bauchi	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Gadarmaiwa, Ningi, Bauchi	23	0.00	n/a	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Uganda	**175**	**0.86**	**0.02**	**0.62**	**0.62**	**0.35**	**0.39**	**0.07**	**0.07**	**0.57**	**92.31%**
Karambi HCIII	25	1.00	0.00	0.60	0.60	0.56	0.52	0.00	0.00	3.28	n/a
Bwera	25	1.00	0.00	0.56	0.60	0.24	0.40	0.04	0.00	2.80	0.00%

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	Maximum = 5	Maximum = 100%
Hoima	25	1.00	0.12	0.96	0.96	0.24	0.12	0.08	0.08	3.28	100.00%
Kitovu	25	1.00	0.00	0.68	0.68	0.28	0.24	0.12	0.12	2.88	100.00%
Masaka RRH	25	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	n/a
Kalungu HCIII	25	0.00	0.00	0.72	0.72	0.44	0.72	0.00	0.00	2.60	n/a
Kagando	25	1.00	0.00	0.84	0.76	0.68	0.72	0.28	0.28	4.00	100.00%
FC+ TOTAL	**676**	**0.62**	**0.24**	**0.48**	**0.51**	**0.44**	**0.44**	**0.05**	**0.04**	**1.92**	**0.95**

APPENDIX N: FC+ ANNUAL PARTOGRAPH MONITORING: FY 15/16

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	**Maximum = 5**	**Maximum = 100%**
Bangladesh	**136**	**0.59**	**n/a**	**0.56**	**0.81**	**0.98**	**0.98**	**0.34**	**0.34**	**3.92**	**100.00%**
LAMB	25	1.00		0.92	1.00	1.00	1.00	1.00	1.00	4.92	100.00%
Ad-din Dhaka	25	0.92		0.88	0.92	0.88	0.88	0.00	0.00	4.48	n/a
Ad-din Khulna	11	1.00		1.00	1.00	1.00	1.00	1.00	1.00	5.00	100.00%
BSMMU	25	0.00		0.00	1.00	1.00	1.00	0.00	0.00	3.00	n/a
Kumudini	25	0.60		0.56	0.96	1.00	1.00	0.04	0.04	4.12	100.00%
Muttalib	25	0.00		0.00	0.00	1.00	1.00	0.00	0.00	2.00	n/a
Niger	**50**	**1.00**	**0.00**	**0.50**	**0.50**	**1.00**	**1.00**	**0.00**	**0.00**	**4.00**	**n/a**
CSME Maradi	25	1.00		0.40	0.40	1.00	1.00	0.00	0.00	3.80	n/a
CSME Tahoua	25	1.00		0.60	0.60	1.00	1.00	0.00	0.00	4.20	n/a
Uganda	**397**	**0.51**	**0.00**	**0.71**	**0.68**	**0.39**	**0.35**	**0.12**	**0.09**	**2.59**	**78.43%**
Karambi HCIII	25	0.00		0.80	0.80	0.28	0.28	0.00	0.00	1.36	n/a
Bwera	25	0.88		0.48	0.44	0.20	0.20	0.16	0.16	2.20	100.00%

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	Maximum = 5	Maximum = 100%
Hoima	25	0.64		0.56	0.56	0.08	0.08	0.04	0.04	1.92	100.00%
Kiyumba HCIV	25	0.00		0.92	0.96	0.68	0.64	0.32	0.32	3.20	100.00%
Jinja	25	0.96		0.28	0.24	0.12	0.12	0.08	0.08	1.72	100.00%
Kamuli	25	1.00		0.76	0.60	0.52	0.44	0.08	0.00	3.32	0.00%
Kigorobya HCIV	25	0.00		0.96	0.92	0.68	0.64	0.28	0.24	3.20	85.71%
Kyanamukaaka HCIV	25	0.00		1.00	1.00	0.52	0.56	0.08	0.08	3.08	100.00%
Buraru HCIII	22	0.00		0.88	0.88	0.72	0.16	0.28	0.28	2.64	100.00%
Azur HCIV	25	1.00		0.68	0.72	0.04	0.00	0.24	0.12	2.44	50.00%
Buseruka HCIII	25	0.00		0.96	0.84	0.56	0.52	0.28	0.20	2.88	71.43%
Kikuube HCIV	25	0.48		0.92	0.88	0.64	0.68	0.00	0.00	3.60	n/a
Kitovu	25	1.00		0.68	0.68	0.32	0.48	0.00	0.00	3.16	n/a
Masaka RRH	25	1.00		0.92	0.88	0.44	0.24	0.04	0.04	3.48	n/a
Kalungu HCIII	0	0.00		0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
Rwesande HCIV	25	0.72		0.56	0.52	0.36	0.36	0.04	0.00	2.52	0.00%
Kagando	25	1.00		0.68	0.68	0.44	0.48	0.12	0.04	3.28	33.33%

Facility name	Number records reviewed	5. Partograph in patient file?	6. Partograph from a referring facility in patient file?	7. Contractions (1/2hrly throughout labor)	8. Fetal Heart Rate (1/2 hrly throughout labor)	9. Maternal Blood Pressure (EITHER A. - at admission or B. - throughout labor)	10. Maternal Pulse (EITHER A. - at admission or B. - throughout labor)	11. Cross Action line?	12. Actions Taken? (Quantitative)	Indicator A (Mean Score)	Indicator B (% Correct Action)
		0: No, not in file 1: Yes, in file	0: No, not in file; 1: Yes, in file; N/A: not referred; DK: source cannot be determined	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not recorded; 1: Yes, Recorded	0: No, not crossed; 1: crossed	0: No, appropriate actions not taken; 1:Yes, appropriate actions taken	Maximum = 5	Maximum = 100%
DRC	**75**	**0.74**	**0.00**	**0.48**	**0.35**	**0.72**	**0.72**	**0.01**	**0.01**	**3.01**	**100.00%**
Heal Africa	25	1		0.44	0.24	0.92	0.92	0.00	0.00	3.52	n/a
St. Joseph	25	0.96		0.72	0.72	1.00	1.00	0.04	0.04	4.40	100%
Esengo	25	1		0.76	0.44	0.96	0.96	0.00	0.00	4.12	n/a
MSRK	0	0		0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/a
FC+ TOTAL	**658**	**0.71**		**0.56**	**0.59**	**0.77**	**0.76**	**0.12**	**0.11**	**3.38**	**0.94**

APPENDIX O: FC/ FC+ PEER REVIEWED PUBLICATIONS[31]

I. Published

- Arrowsmith SD, Ruminjo J, Landry EG. Current practices in treatment of female genital fistula: a cross sectional study. *BMC Pregnancy Childbirth*. 2010 Nov 10;10:73.

BACKGROUND: Background: Maternal outcomes in most countries of the developed world are good. However, in many developing/resource-poor countries, maternal outcomes are bleaker: Every year, more than 500,000 women die in childbirth, mostly in resource-poor countries. Those who survive often suffer from severe and long-term morbidities. One of the most devastating injuries is obstetric fistula, occurring most often in south Asia and sub-Saharan Africa. Fistula treatment and care are available in many countries across Africa and Asia, but there is a lack of reliable data around clinical factors associated with the success of fistula repair surgery. Most published research has been retrospective. While these studies have provided useful information about the care and treatment of fistula, they are limited by the design. This study was designed to identify practices in care that could lead to the design of prospective and randomized controlled trials. METHODS: Self-administered questionnaires were completed by 40 surgeons known to provide fistula treatment services in Africa and Asia at private and government hospitals. The questionnaire was divided into three parts to address the following issues: prophylactic use of antibiotics before, during, and after fistula surgery; urethral catheter management; and management practices for patients with urinary incontinence following fistula repair. RESULTS: The results provide a glimpse into current practices in fistula treatment and care across a wide swath of geographic, economic, and organizational considerations. There is consensus in treatment in some areas (routine use of prophylactic antibiotics, limited bed rest until the catheter is removed, nonsurgical treatment for postsurgical incontinence), while there are wide variations in practice in other areas (duration of catheter use, surgical treatments for postsurgical incontinence). These findings are based on a small sample and do not allow for recommending changes in clinical care, but they point to issues for possible clinical trial research that would contribute to more efficient and effective fistula care. CONCLUSIONS: The findings from the survey allowed us to consider clinical practices most influential in the cost, efficacy, and safety of fistula treatment. These considerations led us to formulate recommendations for eight randomized controlled trials on the following subjects: 1) Efficacy/safety of short-term catheterization; 2) efficacy of surgical and nonsurgical therapies for urinary incontinence; 3) technical measures during fistula repair to reduce the incidence of post-surgery incontinence; 4) identification of predictive factors for "incurable fistula"; 5) usefulness of urodynamic studies in the management of urinary incontinence; 6) incidence and significance of multi-drug resistant bacteria in the fistula population; 7) primary management of small, new fistulas by catheter drainage; and 8) antibiotic prophylaxis in fistula repair.

- Arrowsmith SD, Barone MA, Ruminjo J. Outcomes in obstetric fistula care: a literature review. *Curr Opin Obstet Gynecol*. 2013 Oct;25(5):399-403.

PURPOSE OF REVIEW: To highlight the lack of consistency in the terminology and indicators related to obstetric fistula care and to put forward a call for consensus. RECENT FINDINGS: Recent studies show at least some degree of statistical correlation between outcome and the following clinical factors: degree of scarring/fibrosis, fistula location, fistula size, damage to the urethra, presence of circumferential fistula, bladder capacity, and prior attempt at fistula repair. SUMMARY: Consensus about basic definitions of clinical success does not yet exist. Opinions vary widely about the prognostic parameters for success or failure. Commonly agreed upon definitions and outcome measures will help ensure that site reviews are accurate and conducted fairly. To properly compare technical innovations with existing methods, agreement must be reached on definitions of success. Standardized indicators for mortality and morbidity associated with fistula repair will improve the evidence base and contribute to quality of care.

[31] This summarizes all peer-reviewed publications throughout the life of both the FC and FC+ projects, as of March 2016.

- Barone M, Widmer M, Arrowsmith S, Ruminjo J, Seuc A, Landry E, Hamidou Barry T, Danladi D, Djangnikpo L, Gbawuru-Mansaray T, Harou I, Lewis A, Muleta M, Nembunzu D, Olupot R, Sunday-Adeoye I, Wakasiaka WK, Landoulsi S, Delamou A, Were L, Frajzyngier V, Beattie K, A Gülmezoglu AM. 7 day bladder catheterization is not inferior to 14 day catheterization following repair of female genital fistula: a randomized controlled, non-inferiority trial. *Lancet*. 2015 Jul 4;386(9988):56-62.

BACKGROUND: Duration of bladder catheterization after female genital fistula repair varies widely. We aimed to establish whether 7 day bladder catheterization was not inferior to 14 days in terms of incidence of fistula repair breakdown among women with simple fistula. METHODS: We conducted a non-inferiority randomized controlled trial at eight hospitals in eight African countries. Women with a simple fistula that was closed after surgery and that remained closed until postoperative day 7 were eligible. Participants were randomized in a 1:1 ratio to 7 or 14-day bladder catheterization. The primary outcome was fistula repair breakdown, based on dye test results, any time after day 7 after catheter removal up to 3 months post-surgery. Secondary outcomes included: repair breakdowns at 7 days after catheter removal or thereafter, urinary retention on day 1, 3 and/or 7 after catheter removal; infections and febrile episodes potentially related to the treatment; catheter blockage; prolonged hospitalization; and residual incontinence at 3 months. The trial is registered with ClinicalTrials.gov, Identifier NCT01428830. FINDINGS: 524 participants were randomized and followed up between January 2012 and August 2013; 261 in the 7-day group and 263 in the 14-day group. The analysis population included 250 participants in the 7-day group and 251 in the 14-day group. There was no significant difference in the rate of fistula repair breakdown between the groups (risk difference 0.8%; 95% CI -2.8-4.5). There were no significant differences in the secondary outcomes between the groups. INTERPRETATION: 7 day bladder catheterization after repair of simple fistula was non-inferior to 14 day catheterization. It is safe and effective for managing women following repair of simple fistula without a significant increased risk of repair breakdown, urinary retention or residual incontinence through 3 months after surgery.

- Barone MA, Frajzyngier V, Arrowsmith S, Ruminjo J, Seuc A, Landry E, Beattie K, Barry TH, Lewis A, Muleta M, Nembunzu D, Olupot R, Sunday-Adeoye I, Wakasiaka WK, Widmer M, Gülmezoglu AM. Non-inferiority of short-term urethral catheterization following fistula repair surgery: study protocol for a randomized controlled trial. *BMC Womens Health*. 2012 Mar 20;12:5.

BACKGROUND: A vaginal fistula is a devastating condition, affecting an estimated 2 million girls and women across Africa and Asia. There are numerous challenges associated with providing fistula repair services in developing countries, including limited availability of operating rooms, equipment, surgeons with specialized skills, and funding from local or international donors to support surgeries and subsequent post-operative care. Finding ways of providing services in a more efficient and cost-effective manner, without compromising surgical outcomes and the overall health of the patient, is paramount. Shortening the duration of urethral catheterization following fistula repair surgery would increase treatment capacity, lower costs of services, and potentially lower risk of healthcare-associated infections among fistula patients. There is a lack of empirical evidence supporting any particular length of time for urethral catheterization following fistula repair surgery. This study will examine whether short-term (7 day) urethral catheterization is not worse by more than a minimal relevant difference to longer-term (14 day) urethral catheterization in terms of incidence of fistula repair breakdown among women with simple fistula presenting at study sites for fistula repair service. METHODS/DESIGN: This study is a facility-based, multicenter, non-inferiority randomized controlled trial (RCT) comparing the new proposed short-term (7 day) urethral catheterization to longer-term (14 day) urethral catheterization in terms of predicting fistula repair breakdown. The primary outcome is fistula repair breakdown up to three months following fistula repair surgery as assessed by a urinary dye test. Secondary outcomes will include repair breakdown one week following catheter removal, intermittent catheterization due to urinary retention and the occurrence of septic or febrile episodes, prolonged hospitalization for medical reasons, catheter blockage, and self-reported residual incontinence. This trial will be conducted among 512 women with simple fistula presenting at 8 study sites for fistula repair surgery over the course of 24 months at each site. DISCUSSION: If no major safety issues are identified, the data from this trial may facilitate adoption of short-term urethral catheterization following repair of simple fistula in sub-Saharan Africa and Asia. TRIAL REGISTRATION: ClinicalTrials.gov Identifier NCT01428830.

- Barone MA, Frajzyngier V, Ruminjo J, Asiimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Lynch M, Mussell F, Podder DC. Determinants of postoperative outcomes of female genital fistula repair surgery. *Obstetrics and Gynecology*. 2012 Sep;120(3):524-31.

OBJECTIVE: To determine predictors of fistula repair outcomes 3 months postsurgery. METHODS: We conducted a multicountry prospective cohort study between 2007 and 2010. Outcomes, measured 3 months postsurgery, included fistula closure and residual incontinence in women with a closed fistula. Potential predictors included patient and fistula characteristics and context of repair. Multivariable generalized estimating equation models were used to generate adjusted risk ratios (RRs) and 95% confidence intervals (CIs). RESULTS: Women who returned for follow-up 3-month postsurgery were included in predictors of closure analyses (n=1,274). Small bladder size (adjusted RR 1.57, 95% CI 1.39-1.79), prior repair (adjusted RR 1.40, 95% CI 1.11-1.76), severe vaginal scarring (adjusted RR 1.56, 95% CI 1.20-2.04), partial urethral involvement (adjusted RR 1.36, 95% CI 1.11-1.66), and complete urethral destruction or circumferential defect (adjusted RR 1.72, 95% CI 1.33-2.23) predicted failed fistula closure. Women with a closed fistula at 3-month follow-up were included in predictors of residual incontinence analyses (n=1,041). Prior repair (adjusted RR 1.37, 95% CI 1.13-1.65), severe vaginal scarring (adjusted RR 1.35, 95% CI 1.10-1.67), partial urethral involvement (adjusted RR 1.78, 95% CI 1.27-2.48), and complete urethral destruction or circumferential defect (adjusted RR 2.06, 95% CI 1.51-2.81) were significantly associated with residual incontinence. CONCLUSION: The prognosis for genital fistula closure is related to preoperative bladder size, previous repair, vaginal scarring, and urethral involvement.

- Brazier E, Fiorentino R, Barry MS, Diallo M. The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea. *Health Policy and Planning* Health Policy Plan. 2015 Sep;30(7):885-94.

BACKGROUND: This paper presents results from a community-level intervention that promoted use of maternal health services as a means of preventing obstetric fistula. Implemented in the Republic of Guinea, the intervention aimed to build the capacity of community-level committees to heighten awareness about maternal health risks and to promote use of professional maternal health services. METHODS: Data were collected through a population-based survey. A total of 2,335 women of reproductive age were interviewed, including 878 with a live birth or stillbirth since the launch of the intervention. An index of community capacity was created to explore the effect of living in a community with strong community-level resources and support for maternal health. Other composite variables were created to measure the content of women's antenatal counseling and their individual exposure to maternal health promotion activities at the community level. Multivariate logistic regression was used to explore the effect of community capacity and individual exposure variables on women's use of antenatal care ($\geq$ 4 visits), institutional delivery, and care for complications. RESULTS: Women living in communities with a high score on the community capacity index were more than twice as likely as women in communities with low score to attend at least four ANC visits, to deliver in a health facility, and to seek care for perceived complications. CONCLUSIONS: Building the capacity of community-level cadres to promote maternity care-seeking by women in their villages is an important complement to facility-level interventions to increase the availability, quality, and utilization of essential health services.

- Brazier E, Fiorentino R, Barry S, Kasse Y, Millimono S. Rethinking how to promote maternity care-seeking: factors associated with institutional delivery in Guinea. *Health Care Women Int*. 2014 Sep;35(7-9):878-95.

This paper presents findings from a study on women's delivery care-seeking in two regions of Guinea. We explored exposure to interventions promoting birth preparedness and complication readiness among women with recent live births and stillbirths. Using multivariate regression models, we identified factors associated with women's knowledge and practices related to birth preparedness, as well as their use of health facilities during childbirth. We found that women's knowledge about preparations for any birth (normal or complicated) was positively associated with increased preparation for birth, which itself was associated with institutional delivery. Knowledge about obstetric risks and danger signs, was not associated with birth preparation or with institutional delivery. The study

findings highlight the importance of focusing on preparation for all births—and not simply obstetric emergencies—in interventions aimed at increasing women's use of skilled maternity care.

- Delamou, A., Delvaux, T., Utz, B., Camara, B. S., Beavogui, A. H., Cole, B., Levin, K., Diallo, M., Millimono, S., Barry, T. H., El Ayadi, A. M., Zhang, W.-H. and De Brouwere, V. Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea. *Tropical Medicine & International Health*. 2015 Nov;20(11):1454-1461.

Objectives: To analyse the trend of loss to follow-up over time and identify factors associated with women being lost to follow-up after discharge in three fistula repair hospitals in Guinea. Methods: This retrospective cohort study used data extracted from medical records of fistula repairs conducted from 1 January 2007 to 30 September 2013. A woman was considered lost to follow-up if she did not return within 4 months post-discharge. Factors associated with loss to follow-up were identified using a subsample of the data covering the period 2010–2013. Results: Over the study period, the proportion of loss to follow-up was 21.5% (448/2080) and varied across repair hospitals and over time with an increase from 2% in 2009 to 52% in 2013. After adjusting for other variables in a multivariate logistic regression model, women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be lost to follow-up than women operated at Jean Paul II hospital (OR: 50.6; 95% CI: 24.9–102.8) and (OR: 11.5; 95% CI: 6.1–22.0), respectively. Women with their fistula closed at hospital discharge (OR: 3.2; 95% CI: 2.1–4.8) and women admitted for repair in years 2011–2013 showed higher loss to follow-up as compared to 2010. Finally, loss to follow-up increased by 2‰ for each additional kilometre of distance a client lived from the repair hospital (OR: 1.002; 95% CI: 1.001–1.003). Conclusion: Reimbursement of transport was the likely reason for change over time of LTFU. Reducing geographical barriers to care for women with fistula could sustain fistula care positive outcomes.

- Delamou, A., Diallo, M., Beavogui, A. H., Delvaux, T., Millimono, S., Kourouma, M., Beattie, K., Barone, M., Barry, T. H., Khogali, M., Edginton, M., Hinderaker, S. G., Ruminjo, J., Zhang, W.-H. and De Brouwere, V. Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea. *Tropical Medicine & International Health*. 2015 20: 813–819.

OBJECTIVES: Female genital fistula remains a public health concern in developing countries. From January 2007 to September 2013, the Fistula Care project, managed by EngenderHealth in partnership with the Ministry of Health and supported by USAID, integrated fistula repair services in the maternity wards of general hospitals in Guinea. The objective of this article was to present and discuss the clinical outcomes of 7 years of work involving 2116 women repaired in three hospitals across the country. METHODS: This was a retrospective cohort study using data abstracted from medical records for fistula repairs conducted from 2007 to 2013. The study data were reviewed during the period April to August 2014. RESULTS: The majority of the 2116 women who underwent surgical repair had vesicovaginal fistula (***n*** = 2045, 97%) and 3% had rectovaginal fistula or a combination of both. Overall 1748 (83%) had a closed fistula and were continent of urine immediately after surgery. At discharge, 1795 women (85%) had a closed fistula and 1680 (79%) were dry, meaning they no longer leaked urine and/or faeces. One hundred and fifteen (5%) remained with residual incontinence despite fistula closure. Follow-up at 3 months was completed by 1663 (79%) women of whom 1405 (84.5%) had their fistula closed and 80% were continent. Twenty-one per cent were lost to follow-up. CONCLUSION: Routine programmatic repair for obstetric fistula in low resources settings can yield good outcomes. However, more efforts are needed to address loss to follow-up, sustain the results and prevent the occurrence and/or recurrence of fistula.

- Delamou, A, Samadari, G, Camara BS, Traore P, Diallo F, Millimono S, Wane D, Toliver M, Laffe K, Verani F. Prevalence and correlates of intimate partner violence among family planning clients in Conakry, Guinea. *BMC Research Notes.* 2015 8:814

Intimate partner violence (IPV) is a global public health problem that affects women's physical, mental, sexual and reproductive health. Very little data on IPV experience and FP use is available in resource-poor settings, such as in West Africa. The aim of this study was to describe the prevalence, patterns and correlates of IPV among clients of an adult Family Planning clinic in Conakry, Guinea. The study data was collected for four months (March to June

2014) from women's family planning charts and from an IPV screening form at the Adult Family Planning and Reproductive Health Clinic of "Association Guinéenne pour le Bien-Etre Familial", a non-profit organization in Conakry, Guinea. 232 women out of 245 women who attended the clinic for services during the study period were screened for IPV and were included in this study. Of the 232 women screened, 213 (92 %) experienced IPV in one form or another at some point in their lifetime. 169 women reported psychological violence (79.3 %), 145 reported sexual violence (68.1 %) and 103 reported physical violence (48.4 %). Nearly a quarter of women reported joint occurrence of the three forms of violence (24 %).Half of the IPV positive women were current users of family planning (51.2 %) and of these, 77.9 % preferred injectable contraceptives. The odds of experiencing IPV was higher in women with secondary or vocational level of education than those with higher level of education (AOR: 8.4; 95 % CI 1.2–58.5). Women residing in other communes of Conakry (AOR: 5.6; 95 % CI 1.4–22.9) and those preferring injectable FP methods (AOR: 4.5; 95 % CI 1.2–16.8) were more likely to experience lifetime IPV. IPV is prevalent among family planning clients in Conakry, Guinea where nine out of ten women screened in the AGBEF adult clinic reported having experienced one or another type of IPV. A holistic approach that includes promotion of women's rights and gender equality, existence of laws and policies is needed to prevent and respond to IPV, effective implementation of policies and laws, and access to quality IPV services in Guinea and countries with higher rates of IPV.

- Frajzyngier V, Ruminjo J, Asiimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Lynch M, Mussell F, Podder DC, Barone MA. Factors influencing choice of surgical route of repair of genitourinary fistula, and the influence of route of repair on surgical outcomes: findings from a prospective cohort study. *BJOG*. 2012 Oct;119(11):1344-53.

OBJECTIVE: The abdominal route of genitourinary fistula repair may be associated with longer-term hospitalisation, hospital-associated infection and increased resource requirements. We examined: (1) the factors influencing the route of repair; (2) the influence of the route of repair on fistula closure 3 months following surgery; and (3) whether the influence of the route of repair on repair outcome varied by whether or not women met the published indications for abdominal repair. DESIGN: Prospective cohort study. SETTING: Eleven health facilities in sub-Saharan Africa and Asia. POPULATION: The 1274 women with genitourinary fistula presenting for surgical repair services. METHODS: Risk ratios (RRs) and 95% confidence intervals (95% CIs) were generated using log-binomial and Poisson (log-link) regression. Multivariable regression and propensity score matching were employed to adjust for confounding. MAIN OUTCOME MEASURES: Abdominal route of repair and fistula closure at 3 months following fistula repair surgery. RESULTS: Published indications for abdominal route of repair (extensive scarring or tissue loss, genital infibulation, ureteric involvement, trigonal, supratrigonal, vesico-uterine or intracervical location or other abdominal pathology) predicted the abdominal route [adjusted risk ratio (ARR), 15.56; 95% CI, 2.12-114.00]. A vaginal route of repair was associated with increased risk of failed closure (ARR, 1.41; 95% CI, 1.05-1.88); stratified analyses suggested elevated risk among women meeting indications for the abdominal route. CONCLUSIONS: Additional studies powered to test effect modification hypotheses are warranted to confirm whether the abdominal route of repair is beneficial for certain women.

- Frajzyngier V, Ruminjo J, Barone MA. Factors influencing urinary fistula repair outcomes in developing countries: a systematic review. *Am J Obstet Gynecol*. 2012 Oct;207(4):248-58.

We reviewed literature examining predictors of urinary fistula repair outcomes in developing country settings, including fistula and patient characteristics, and perioperative factors. We searched Medline for articles published between January 1970 and December 2010, excluding articles that were (1) case reports, cases series or contained 20 or fewer subjects; (2) focused on fistula in developed countries; and (3) did not include a statistical analysis of the association between facility or individual-level factors and surgical outcomes. Twenty articles were included; 17 were observational studies. Surgical outcomes included fistula closure, residual incontinence after closure, and any incontinence (dry vs wet). Scarring and urethral involvement were associated with poor prognosis across all outcomes. Results from randomized controlled trials examining prophylactic antibiotic use and repair outcomes were inconclusive. Few observational studies examining perioperative interventions accounted for confounding by fistula severity. We conclude that a unified, standardized evidence-base for informing clinical practice is lacking.

- Frajzyngier V, Li G, Larson E, Ruminjo J, Barone MA. Development and comparison of prognostic scoring systems for surgical closure of genitourinary fistula. *Am J Obstet Gynecol*. 2013 Feb;208(2):112.e1-11.

OBJECTIVE: The purpose of this study was to test the diagnostic performance of 5 existing classification systems (developed by Lawson, Tafesse, Goh, Waaldijk, and the World Health Organization) and a prognostic scoring system that was derived empirically from our data to predict fistula closure 3 months after surgery. STUDY DESIGN: Women with genitourinary fistula (n = 1274) who received surgical repair services at 11 health facilities in sub-Saharan Africa and Asia were enrolled in a prospective cohort study. Using one-half of the sample, we created multivariate generalized estimating equation models to obtain weighted prognostic scores for components of each existing classification system and the empirically derived scoring system. With the second one-half, we developed receiver operating characteristic curves using the prognostic scores and calculated areas under the curves (AUCs) and 95% confidence intervals (CIs) for each system. RESULTS: Among existing systems, the scoring systems that represented the World Health Organization, Goh, and Tafesse classifications had the highest predictive accuracy: AUC, 0.63 (95% CI, 0.57-0.68); AUC, 0.62 (95% CI, 0.57-0.68), and AUC, 0.60 (95% CI, 0.55-0.65), respectively. The empirically derived prognostic score achieved similar predictive accuracy (AUC, 0.62; 95% CI, 0.56-0.67); it included significant predictors of closure that are found in the other classification systems, but contained fewer, nonoverlapping components. The differences in AUCs were not statistically significant. CONCLUSION: The prognostic values of existing urinary fistula classification systems and the empirically derived score were poor to fair. Further evaluation of the validity and reliability of existing classification systems to predict fistula closure is warranted; consideration should be given to a prognostic score that is evidence-based, simple, and easy to use.

- Landry E, Pett C, Forentino R, Ruminjo J, Mattison C. Assessing the quality of record keeping for cesarean deliveries: results from a multicenter retrospective record review in five low-income countries. *BMC Pregnancy and Childbirth.* Under review. Requested revisions submitted.

BACKGROUND: Reliable, timely information is the foundation of decision making for functioning health systems; the quality of decision making rests on quality data. Routine monitoring, reporting, and review of cesarean section (CS) indications, decision-to-delivery intervals, and partograph use are important elements of quality improvement for maternity services. METHODS: In 2009 and 2010, a sample of CS delivery records from calendar year 2008 was reviewed at nine facilities in Bangladesh, Guinea, Mali, Niger, and Uganda. Data from patient records and hospital registers were collected on key aspects of care (e.g., timing of key events, indications, partograph use, maternal and fetal outcomes). Qualitative interviews were conducted with key informants at all study sites. RESULTS: A total of 2,941 records were reviewed. Fifty-seven key informant interviews were conducted to learn about record-keeping practices. Patient record-keeping systems were of varying quality across study sites: at five sites, more than 20% of records could not be located. Across all sites, patient files were missing key aspects of CS delivery care: timing of key events (e.g., examination, decision to perform CS), administration of prophylactic antibiotics, maternal complications, and maternal and fetal outcomes. Rates of partograph use were disappointingly low at six sites: 0 to 23.9% of patient files at these sites had a completed partograph on file, and among those found, 2.1% to 65.1% were completed correctly. Information on fetal outcomes was missing in up to 40% of patient files. CONCLUSIONS: Deficits in CS patient record data quality across a broad range of health facilities in low-resource settings in four sub-Saharan Africa countries and Bangladesh indicate an urgent need to improve record keeping.

- Landry E, Frajzyngier V, Ruminjo J, Asiimwe F, Barry TH, Bello A, Danladi D, Ganda SO, Idris S, Inoussa M, Kanoma B, Lynch M, Mussell F, Podder DC, Wali A, Mielke E, Barone MA. Profiles and experiences of women undergoing genital fistula repair: findings from five countries. *Glob Public Health*. 2013;8(8):926-42.

This article presents data from 1354 women from five countries who participated in a prospective cohort study conducted between 2007 and 2010. Women undergoing surgery for fistula repair were interviewed at the time of admission, discharge, and at a 3-month follow-up visit. While women's experiences differed across countries, a similar picture emerges across countries: women married young, most were married at the time of admission, had little education, and for many, the fistula occurred after the first pregnancy. Median age at the time of fistula occurrence was 20.0 years (interquartile range 17.3-26.8). Half of the women attended some antenatal care (ANC); among those who attended ANC, less than 50% recalled being told about signs of pregnancy complications. At

follow-up, most women (even those who were not dry) reported improvements in many aspects of social life, however, reported improvements varied by repair outcome. Prevention and treatment programmes need to recognise the supportive role that husbands, partners, and families play as women prepare for safe delivery. Effective treatment and support programmes are needed for women who remain incontinent after surgery.

- Longombe AO, Claude KM, Ruminjo J. Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies. *Reprod Health Matters*. 2008 May;16(31):132-41.

The Eastern region of the Democratic Republic of Congo (DRC) is currently undergoing a brutal war. Armed groups from the DRC and neighbouring countries are committing atrocities and systematically using sexual violence as a weapon of war to humiliate, intimidate and dominate women, girls, their men and communities. Armed combatants take advantage with impunity, knowing they will not be held to account or pursued by police or judicial authorities. A particularly inhumane public health problem has emerged: traumatic gynaecological fistula and genital injury from brutal sexual violence and gang-rape, along with enormous psychosocial and emotional burdens. Many of the women who survive find themselves pregnant or infected with STIs/HIV with no access to treatment. This report was compiled at the Doctors on Call for Service/Heal Africa Hospital in Goma, Eastern Congo, from the cases of 4,715 women and girls who suffered sexual violence between April 2003 and June 2006, of whom 702 had genital fistula. It presents the personal experiences of seven survivors whose injuries were severe and long-term, with life-changing effects. The paper recommends a coordinated effort amongst key stakeholders to secure peace and stability, an increase in humanitarian assistance and the rebuilding of the infrastructure, human and physical resources, and medical, educational and judicial systems.

- Ngongo C, Levin K, Landry E, Sutton I, Ndizeye S. What to measure and why? Experience developing and using novel monitoring indicators in maternal health: the case of obstetric fistula. *Journal of Health Informatics in Developing Countries. 2015 9(1): 14-22.*

The field of obstetric fistula has historically lacked common definitions for measuring outcomes. This paper recounts the process of developing, refining, and using standardized monitoring indicators and approaches as part of a fistula prevention and repair project working in fourteen countries. The process included the development and refinement of clinical indicators, the introduction of standardizing data collection and reporting at partner health facilities, building capacity to use data for decision making locally, nationally, and within the project, institutionalizing data review meetings and partner health facilities, and supporting the introduction of fistula treatment indicators into national Health Management Information Systems to enable continued measurement and support for fistula treatment services. As monitoring in the field of obstetric fistula continues to become more standardized and routine, the multi-country scope of the project enabled a wide-ranging effort through which indicators for a “new” maternal health content area were developed and applied. This experience provides lessons for other initiatives seeking to strengthen monitoring and reporting related to novel or emerging topics in maternal health services.

- Ngongo C, Christie K, Holden J, Ford C, Pett C. Striving for excellence: nurturing midwives' skills in Freetown, Sierra Leone. *Midwifery*. 2013 Oct;29(10):1230-4.

Midwives provide critical, life-saving care to women and babies. Effective midwives must be clinically competent, with the required knowledge, skills, and attitudes to provide quality care. Their success depends on an environment of supportive supervision, continuing education, enabling policies, and access to equipment and referral facilities. In Freetown, Sierra Leone, the Aberdeen Women's Centre launched a maternity unit with an emphasis on striving for excellence and providing ongoing professional development to its staff midwives. Its success was built upon fostering a sense of responsibility and teamwork, providing necessary resources, conforming to evidence-based standards, and building partnerships. An explicit philosophy of care was crucial for guiding clinical decision making. In its first two years of operation, the Aberdeen Women's Centre assisted 2076 births with two maternal deaths and 92 perinatal deaths. In-service education and supportive supervision

facilitated the midwives' professional growth, leading to capable future leaders who are providing exemplary care to delivering mothers and their newborns in Freetown.

- Raassen TJ, Ngongo CJ, Mahendeka MM. Iatrogenic genitourinary fistula: an 18-year retrospective review of 805 injuries. *Int Urogynecol J*. 2014 Dec;25(12):1699-706.

INTRODUCTION: Genitourinary fistula poses a public health challenge in areas where women have inadequate access to quality emergency obstetric care. Fistulas typically develop during prolonged, obstructed labor, but providers can also inadvertently cause a fistula when performing obstetric or gynecological surgery. METHODS: This retrospective study analyzes 805 iatrogenic fistulas from a series of 5,959 women undergoing genitourinary fistula repair in 11 countries between 1994 and 2012. Injuries fall into three categories: ureteric, vault, and vesico-[utero]/-cervico-vaginal. This analysis considers the frequency and characteristics of each type of fistula and the risk factors associated with iatrogenic fistula development. RESULTS: In this large series, 13.2% of genitourinary fistula repairs were for injuries caused by provider error. A range of cadres conducted procedures resulting in iatrogenic fistula. Four out of five iatrogenic fistulas developed following surgery for obstetric complications: cesarean section, ruptured uterus repair, or hysterectomy for ruptured uterus. Others developed during gynecological procedures, most commonly hysterectomy. Vesico-[utero]/-cervico-vaginal fistulas were the most common (43.6%), followed by ureteric injuries (33.9%) and vault fistulas (22.5%). One quarter of women with iatrogenic fistulas had previously undergone a laparotomy, nearly always a cesarean section. Among these women, one quarter had undergone more than one previous cesarean section. CONCLUSIONS: Women with previous cesarean sections are at increased risk for iatrogenic injury. Work environments must be adequate to reduce surgical error. Training must emphasize the importance of optimal surgical techniques, obstetric decision-making, and alternative ways to deliver dead babies. Iatrogenic fistulas should be recognized as a distinct genitourinary fistula category.

- Ruminjo JK, Frajzyngier V, Bashir Abdullahi M, Asiimwe F, Hamidou Barry T, Bello A, Danladi D, Oumarou Ganda S, Idris S, Inoussa M, Lynch M, Mussell F, Chandra Podder D, Wali A, Barone MA. Clinical procedures and practices used in the perioperative treatment of female genital fistula during a prospective cohort study. BMC Pregnancy *Childbirth*. 2014 Jul 5;14:220.

BACKGROUND**:** Treatment and care for female genital fistula have become increasingly available over the last decade in countries across Africa and South Asia. Before the International Federation of Gynaecology and Obstetrics (FIGO) and partners published a global fistula training manual in 2011 there was no internationally recognized, standardized training curriculum, including perioperative care. The community of fistula care practitioners and advocates lacks data about the prevalence of various perioperative clinical procedures and practices and their potential programmatic implications are lacking. METHODS**:** Data presented here are from a prospective cohort study conducted between September 2007 and September 2010 at 11 fistula repair facilities supported by Fistula Care in five countries. Clinical procedures and practices used in the routine perioperative management of over 1300 women are described. RESULTS**:** More than two dozen clinical procedures and practices were tabulated. Some of them were commonly used at all sites (e.g., vaginal route of repair, 95.3% of cases); others were rare (e.g., flaps/grafts, 3.4%) or varied widely depending on site (e.g. for women with urinary fistula, the inter-quartile range for median duration of post-repair bladder catheterization was 14 to 29 days). CONCLUSIONS**:** These findings show a wide range of clinical procedures and practices with different program implications for safety, efficacy, and cost-effectiveness. The variability indicates the need for further research so as to strengthen the evidence base for fistula treatment in developing countries.

- Ruminjo R, Landry E, Beattie K, Isah A, Faisel AJ, Millimono S. Mortality risk associated with surgical treatment of female genital fistula. *International Journal of Gynecology and Obstetrics.* 2014 Apr 18. pii: S0020-7292(14)00194-5.

OBJECTIVE*:* Most surgeries proceed without incident, but all major surgeries have inherent risks for adverse events, including death. Some deaths are attributable to the condition requiring surgery, concurrent morbidity, or the surgery itself. For fistula treatment, published literature on mortality risk is extremely limited. This article

describes the mortality risk associated with surgical treatment of female genital fistula and the contributory and contextual factors. METHODS*:* Confidential inquiries and clinical audits were conducted at 14 fistula repair sites in seven resource-poor countries. Data collection included interviews with key personnel involved in the clinical management of the deceased and a review of hospital records and client files following an audit protocol. RESULTS*:* Thirty deaths occurred from 26,060 fistula repair surgeries from 2005 to 2013, 21 attributable to surgery; the case fatality was 0.08 per 100 procedures. The causes of death for nearly half of the cases were various manifestations of sepsis and inflammation. CONCLUSIONS*:* This case fatality rate for fistula repair surgery is in the same range as comparable gynecologic operations in high-resource settings. Clinical and systemic issues should be addressed to minimize chances of recurrence, improve perioperative care and follow-up, assure prudent referral or deferral of difficult cases, and maintain better records.

- Ruminjo J. 2007. Obstetric fistula and the challenge to maternal health care systems. *IPPF Medical Bulletin* 41(4):3-4. [COMMENTARY – NO ABSTRACT]

- Tripathi V. A literature review of quantitative indicators to measure the quality of labor and delivery care. *International Journal of Gynaecology and Obstetrics.* 2016 Feb:132(2): 139-45.

BACKGROUND: Strengthening measurement of the quality of labor and delivery (L&D) care in low-resource countries requires an understanding of existing approaches. OBJECTIVES: To identify quantitative indicators of L&D care quality and assess gaps in indicators. SEARCH STRATEGY: PubMed, CINAHL Plus, and Embase databases were searched for research published in English between January 1, 1990, and October 31, 2013, using structured terms. SELECTION CRITERIA: Studies describing indicators for L&D care quality assessment were included. Those whose abstracts contained inclusion criteria underwent full-text review. DATA COLLECTION AND ANALYSIS: Study characteristics, including indicator selection and data sources, were extracted via a standard spreadsheet. MAIN RESULTS: The structured search identified 1224 studies. After abstract and full-text review, 477 were included in the analysis. Most studies selected indicators by using literature review, clinical guidelines, or expert panels. Few indicators were empirically validated; most studies relied on medical record review to measure indicators. CONCLUSIONS: Many quantitative indicators have been used to measure L&D care quality, but few have been validated beyond expert opinion. There has been limited use of clinical observation in quality assessment of care processes. The findings suggest the need for validated, efficient consensus indicators of the quality of L&D care processes, particularly in low-resource countries.

- Tripathi V, Stanton C, Strobino D, Bartlett L. Development and Validation of an Index to Measure the Quality of Facility-Based Labor and Delivery Care Processes in Sub-Saharan Africa. *PLoS ONE.* 2015. 10(6): e0129491.

BACKGROUND: High quality care is crucial in ensuring that women and newborns receive interventions that may prevent and treat birth-related complications. As facility deliveries increase in developing countries, there are concerns about service quality. Observation is the gold standard for clinical quality assessment, but existing observation-based measures of obstetric quality of care are lengthy and difficult to administer. There is a lack of consensus on quality indicators for routine intrapartum and immediate postpartum care, including essential newborn care. This study identified key dimensions of the quality of the process of intrapartum and immediate postpartum care (QoPIIPC) in facility deliveries and developed a quality assessment measure representing these dimensions. METHODS & FINDINGS: Global maternal and neonatal care experts identified key dimensions of QoPIIPC through a modified Delphi process. Experts also rated indicators of these dimensions from a comprehensive delivery observation checklist used in quality surveys in sub-Saharan African countries. Potential QoPIIPC indices were developed from combinations of highly-rated indicators. Face, content, and criterion validation of these indices was conducted using data from observations of 1,145 deliveries in Kenya, Madagascar, and Tanzania (including Zanzibar). A best-performing index was selected, composed of 20 indicators of intrapartum/immediate postpartum care, including essential newborn care. This index represented most dimensions of QoPIIPC and effectively discriminated between poorly and well-performed deliveries. CONCLUSIONS: As facility deliveries increase and the global community pays greater attention to the role of care

quality in achieving further maternal and newborn mortality reduction, the QoPIIPC index may be a valuable measure. This index complements and addresses gaps in currently used quality assessment tools. Further evaluation of index usability and reliability is needed. The availability of a streamlined, comprehensive, and validated index may enable ongoing and efficient observation-based assessment of care quality during labor and delivery in sub-Saharan Africa, facilitating targeted quality improvement.

- Tunçalp O, Tripathi V, Landry E, Stanton CK, Ahmed S. Measuring the incidence and prevalence of obstetric fistula: approaches, needs, and recommendations. *Bulletin of the World Health Organization.* 2015 Jan; 93(1):60-62. [COMMENTARY - NO ABSTRACT]

- Tunçalp Ö, Isah A, Landry E, Stanton CK. Community-based screening for obstetric fistula in Nigeria: a novel approach. *BMC Pregnancy Childbirth*. 2014 Jan 24;14:44.

BACKGROUND: Obstetric fistula continues to have devastating effects on the physical, social, and economic lives of thousands of women in many low-resource settings. Governments require credible estimates of the backlog of existing cases requiring care to effectively plan for the treatment of fistula cases. Our study aims to quantify the backlog of obstetric fistula cases within two states via community-based screenings and to assess the questions in the Demographic Health Survey (DHS) fistula module. METHODS: The screening sites, all lower level health facilities, were selected based on their geographic coverage, prior relationships with the communities and availability of fistula surgery facilities in the state. This cross-sectional study included women who presented for fistula screenings at study facilities based on their perceived fistula-like symptoms. Research assistants administered the pre-screening questionnaire. Nurse-midwives then conducted a medical exam. Univariate and bivariate analyses are presented. RESULTS: A total of 268 women attended the screenings. Based on the pre-screening interview, the backlog of fistula cases reported was 75 (28% of women screened). The backlog identified after the medical exam was 26 fistula cases (29.5% of women screened) in Kebbi State sites and 12 cases in Cross River State sites (6.7%). Verification assessment showed that the DHS questionnaire had 92% sensitivity, 83% specificity with 47% positive predictive value and 98% negative predictive value for identifying women afflicted by fistula among women who came for the screenings. CONCLUSIONS: This methodology, involving effective, locally appropriate messaging and community outreach followed up with medical examination by nurse-midwives at lower level facilities, is challenging, but represents a promising approach to identify the backlog of women needing surgery and to link them with surgical facilities.

II. In press/under review/in draft

- Landry E, Pett C, Forentino R, Ruminjo J, Mattison C. Determining the feasibility of a cesarean indication classification system from a retrospective record review in five countries. *Being revised and e-published as a technical brief.*

BACKGROUND: Cesarean section (CS) rates continue to rise around the world, raising concerns about the under and overuse of this life saving procedure. While CS audits may be carried out in many countries, there is no internationally accepted standardized classification system for CS. Indication based classification systems can help answer the question about why the CS was performed and these data are generally available in maternity wards. Regular review of cesarean indication trends at the facility level is recommended as a useful indicator to monitor the appropriate use of CS for valid clinical reasons. Regular review of indications could assist in understanding why CS rates are changing. The objective of this study is to assess the feasibility of applying the Immpact/International Federation of Gynecology and Obstetrics (FIGO) classification system, using indication data from a retrospective records review. METHODS: A multicenter retrospective record review of CS that took place in 2008 was carried out at nine facilities in five countries between 2009 and 2010. A total of 2,941 cesarean delivery records were reviewed. The Immpact/FIGO classification system based on absolute maternal and nonabsolute indication categories was applied retrospectively to the primary indication data. Key informant interviews were conducted with 57 hospital staff. RESULTS: Ninety-nine percent of all records reviewed had at least one indication recorded.

None of the sites were using any formally documented CS classification system. A wide range of terminology to describe CS indications was found in patient records. Applying the Immpact/FIGO classification, CS performed for absolute maternal indications ranged from 11.1% to 81.6%, while CS for nonabsolute indications ranged from 17.3% to 62.9%. Key informants were unanimous that CS records need to include a clearly documented, standardized indication in order to facilitate clinical audit. Most providers interviewed at the study sites thought that this system seemed feasible to implement because of its relative simplicity. CONCLUSION: While the key informants were positive about feasibility of implementing the Immpact/FIGO classification, the practicality is unclear given the wide range of terminology utilized by providers across sites. This analysis highlights the potential challenges for reaching agreement on standardized indications.

- Tripathi V, Romanzi L. Comment: Integration of pelvic organ prolapse and genital fistula repair in low-resource settings. *Comment. Being revised for journal resubmission*

- Morgan L, Tripathi V. Genital Fistula and Gender-based Violence: Cause or consequence? *Being revised for journal resubmission*

Objective: Female genital fistula usually results from prolonged/obstructed labor, but can also be traumatic or iatrogenic. As fistula is relatively rare, many studies are limited by small sample sizes, precluding assessment of associations with risk factors and other health concerns. With numerous surveys that include standardized questions on fistula symptoms, the Demographic and Health Surveys (DHS) provide a unique opportunity to evaluate the epidemiology of fistula. This study examined associations between self-reported experience of fistula symptoms and gender-based violence among women interviewed in DHS surveys. *Methods:* This study used data from twelve DHS surveys with standardized fistula and domestic violence modules. Data from 90,276 women were pooled, weighting each survey equally within the total sample. Multivariable logistic regressions controlled for maternal and demographic factors. *Findings*: Prevalence of fistula symptoms ranges from 0.4% to 2.0%. Women who have experienced sexual or physical violence, both ever and recently, are more likely to report symptoms of fistula than women who have not experienced such violence. Women whose first experience of sexual violence was committed by a non-partner have more than four times the odds of reporting fistula symptoms compared to women who never experienced sexual violence. These associations largely persist among women who report that violence did not cause fistula symptoms, indicating a need to further investigate temporal relationships between violence and fistula. *Conclusion*: The increased risk of physical and sexual violence among women with fistula symptoms reported here suggest that fistula programs must incorporate gender-based violence into provider training and service provision.

APPENDIX P: FC/FC+ PUBLICATION READERSHIP METRICS*

TITLE	VIEWS	JOURNAL	PUB YEAR
Obstetric fistula and the challenge to maternal health care systems	n/a	IPPF Medical Bulletin	2007
Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies	n/a	Reproductive Health Matters	2008
Current practices in treatment of female genital fistula: a cross sectional study	7746	BMC Pregnancy and Childbirth	2010
Determinants of postoperative outcomes of female genital fistula repair surgery.	n/a	Obstetrics and Gynecology	2012
Factors influencing choice of surgical route of repair of genitourinary fistula, and the influence of route of repair on surgical outcomes: findings from a prospective cohort study	n/a	BJOG	2012
Factors influencing urinary fistula repair outcomes in developing countries: a systematic review	n/a	American Journal of Obstetrics and Gynecology	2012
Non-inferiority of short-term urethral catheterization following fistula repair surgery: study protocol for a randomized controlled trial	4481	BMC Women's Health	2012
Development and comparison of prognostic scoring systems for surgical closure of genitourinary fistula.	n/a	American Journal of Obstetrics and Gynecology	2013
Outcomes in obstetric fistula care: a literature review	n/a	Current Opinion in Obstetrics and Gynecology	2013
Profiles and experiences of women undergoing genital fistula repair: findings from five countries	1548	Global Public Health	2013
Striving for excellence: nurturing midwives' skills in Freetown, Sierra Leone.	n/a	Midwifery	2013
Assessing the quality of record keeping for cesarean deliveries: results from a multicenter retrospective record review in five low-income countries.	1490	BMC Pregnancy and Childbirth	2014
Clinical Procedures and Practices Used in the Perioperative Treatment of Female Genital Fistula during a Prospective Cohort Study.	1548	BMC Pregnancy and Childbirth	2014
Community-based screening for obstetric fistula in Nigeria: a novel approach	2535	BMC Pregnancy and Childbirth	2014
Iatrogenic genitourinary fistulas: An 18-year retrospective review of 801 iatrogenic injuries	n/a	International Journal of Urogynecology	2014
Rethinking how to promote careseeking: Factors associated with institutional delivery in Guinea	n/a**	Health Care for Women International	2014
Measuring the incidence and prevalence of obstetric fistula: approaches, needs, and recommendations	n/a	Bulletin of the World Health Organization	2014
Mortality risk associated with surgical treatment of female genital fistula.	228***	International Journal of Gynecology and Obstetrics	2014
The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea.	n/a	Health Policy and Planning	2014
Breakdown of simple female genital fistula repair after 7 day versus 14 day postoperative bladder catheterisation: a randomised, controlled, open-label, non-inferiority trial	n/a	The Lancet	2015
Development and validation of an index to measure facility-based labor and delivery care processes in sub-Saharan Africa.****	5570	PLOS ONE	2015
Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea	n/a	Tropical Medicine and International Health	2015

TITLE	VIEWS	JOURNAL	PUB YEAR
Good clinical outcomes from a 7-year holistic programme of fistula repair in Guinea.	n/a	Tropical Medicine and International Health	2015
What to measure and why. Experience developing monitoring indicators for an emerging maternal health issue: the case of obstetric fistula"	n/a	Journal of Health Informatics in Developing Countries	2015
TOTAL	**25,146**		

* Metrics only available for 8 of the 21 published articles.

** Published through the Maternal and Child Health Integration Program/Maternal and Child Survival Program.

*** Due to a change in web platform, updated metrics are no longer available. This number reflects views through late 2014.
****Though metrics are not available, this was one of the top three most downloaded articles in Health Care for Women International in 2014.)
Updated 10/15/2016.

APPENDIX Q: FC+ SUPPORTED TREATMENT SITES MEETING TO DISCUSS DATA IN FY15/16

Country/Site	Q1	Q2	Q3	Q4	Total Number of Meetings in FY 15/16
Fistula Care *Plus* Total: 34 treatment sites[32]					**97% met at least twice 68% met at least once**
Bangladesh: 8 treatment sites					**88% met at least twice 100% met at least once**
Ad-Din Dhaka	0	1	1	1	3
Ad-Din Jessore	0	1	0	0	1
Ad-Din Khulna	0	1	1	0	2
Kumudini Hospital	0	1	1	1	3
LAMB Hospital	0	1	1	1	3
Bangabandhu Sheikh Mujib Medical University	0	1	1	1	3
Dr. Muttalib Community Hospital	0	1	1	1	3
Mamm's Institute of Fistula & Women's Health	0	1	1	1	3
DRC: 5 treatment sites					**60% met at least twice 80% met at least once**
St. Joseph's Hospital/Satellite Maternity Kinshasa	0	0	1	2	3
Panzi Hospital	0	0	0	0	0
HEAL Africa	1	0	1	0	2
IGL	0	0	1	0	1
MSRK	1	1	1	0	3
WA/Niger: 3 treatment sites					**100% met at least twice 100% met at least once**
Centre de Santé Mère / Enfant (CSME) Maradi	1	1	1	1	1
Centre National de Référence des Fistules Obstétricales (CNRFO),Niamey	1	1	1	1	1
Centre de Santé Mère /Enfant (CSME) Tahoua	1	1	1	1	1
Nigeria: 14 treatment sites[33]					**100% met at least twice 100% met at least once**
General Hospital, Ningi	1	1	1	1	4

[32] Supported sites not providing repairs during FY 15/16 (2 sites) are not included in the total or denominator for the data review table.

[33] Support to Evangel VVF Center, the 15th treatment site in Nigeria, was initiated late in FY15/16 and the site did not provide any supported fistula repairs during the year. As a result, there was no data available for review. This site will be added to data review tracking once support for repairs begins.

Country/Site	Q1	Q2	Q3	Q4	Total Number of Meetings in FY 15/16
General Hospital, Ogoja	1	1	1	1	4
National Fistula Center, Abakaliki	1	1	1	1	4
Laure VVF Center	1	1	1	1	4
National Fistula Center, Babbar Ruga, Katsina	1	1	1	1	4
Gesse VVF Center, Birnin Kebbi	1	1	1	1	4
Sobi Specialist Hospital, Ilorin	1	1	1	1	4
Maryam Abatcha Women and Children's Hospital, Sokoto	1	1	1	1	4
Faridat General Hospital, Gusau	1	1	1	1	4
University College Hospital, Ibadan	1	1	1	1	4
Jahun VVF Center, Jigawa State	1	1	1	1	4
Adeoyo General Hospital, Ibadan	1	1	1	1	4
Pope John Paul II Family Life Center	NS	NS	0	1	1
Gambo Sawaba General Hospital	NS	NS	0	1	1
Uganda: 4 treatment sites					**25% met at least twice** **100% met at least once**
Kitovu Mission Hospital	0	0	0	1	1
Hoima Regional Referral Hospital	0	0	1	1	2
Kamuli Mission Hospital	n/a	n/a	0	1	1
Jinja Regional Referral Hospital	n/a	n/a	0	1	1

n/a indicates the site was not supported/did not provide repairs during this quarter

APPENDIX R: NIGERIAN NATIONAL FISTULA SERVICES SUMMARY (INCLUDED IN HMIS)

Fistula Services Monthly Summary Form

IDENTIFICATION

HEALTH

FACILITY_____MONTH_____

POLITICAL

WARD_____YEAR_____

LGA_____Public_____Private___

___

STATE_____Beds_____

__

I. DIAGNOSIS

TOTAL

1	Women seeking care and treatment for urine/stool incontinence					
2	Women seeking treatment for incontinence referred from PHCs					
3	Women seeking treatment for incontinence referred from other sources					
4	Women diagnosed with fistula	VVF only	UVF only	RVF-only	VVF + RVF	
4b	Women with persistent incontinence (WPI)					

5	Fistula by cause (New cases)	Obstructed/ prolonged labour	Iatrogenic (caused by healthcare provider)	Traumatic (sexual violence, other accident)	Others (i.e. cancer, radiation, traditional practices like “gishiri” cut)	

II. Surgical Repair **TOTAL**

6	Fistula clients medically eligible for fistula surgery				
TYPE OF REPAIR		VVF only	UVF only	RVF only	
7	Routine Repair				
8	Pooled Effort Repair				
9	Fistula clients medically eligible for fistula surgery awaiting surgical repair				
SURGICAL ATTEMPTS		VVF ONLY	UVF ONLY	RVF ONLY	VVF + RVF
10	First Attempt				
11	Second Attempt				
12	Third or More Attempt				
SURGICAL OUTCOME					
13.	Women discharged after surgical repair				
14.	Women who are closed & continent at discharge				
15.	Women who are closed but incontinent at discharge				
16.	Women who are not closed at discharge				
17.	Women with VVF +RVF with either not closed at discharge				

III. COMPLICATIONS

18.	Surgery related	Anesthesia related	Vaginal Stenosis (Ba’ - hanya)	Others	TOTAL

IV. CONSERVATIVE FISTULA TREATMENT TOTAL

19.	Clients medically eligible for conservative treatment (urethral catheterization)			
20.	Women Receiving Catheterization			
21.	Women receiving Catheterization who are closed & continent at discharge	Women receiving Catheterization who are closed but incontinent at discharge	Women receiving Catheterization who are not closed at discharge	

V. OTHER PROCEDURES ON FISTULA CLIENTS

22.	Pelvic organ prolapse (POP) surgeries	Operation for stress incontinence (e.g. urethropexy, sling procedure)	Ureteric re-implantation surgery	Anal sphincter repair for faecal incontinence	Bladder stones or foreign body removal	Colostomy and reversal colostomy

VI. Rehabilitation and Re-integration

23.	Does this facility provide rehabilitation services	
24.	Does this facility provide re-integration services	
25.	Fistula clients rehabilitated this month	
26.	Fistula clients fully re-integrated into the community this month	
27.	Rehabilitated fistula clients who started small scale business this month	

APPENDIX S: NIGERIA CLIENT BOOKLET (FIRST PAGE)

FISTULA CLIENT RECORDS

Name of Facility _____ **State:** _____ **LGA:** _____

Date _____ **Hospital Number** _____

Name_____ *Surname middle first name*	**Age** _____years	**Contact's Phone no**

Contact Address
Street/Village: _____
Community/Ward:_____
Local Govt. Area: _____
State: _____
Country:_____

Marital Status (After fistula)
Single…….. ☐
Married & Living with partner …….. ☐
Married but not living with partner… ☐
Widowed ……... ☐
Divorced/Separated …… ☐
Duration of marriage (years): _____

Age at Menarche: How old were you when you first menstruated? _____ years

Did you marry before your first menses?
Yes ☐ No ☐

Highest Educational level?
None…… ☐ Adult Literacy … ☐
Primary … ☐ Arabic School… ☐
Secondary… ☐ Diploma/Certificate…. ☐
University… ☐
Others (specify) _____

Occupation
Client's occupation _____
Husband's occupation _____

Next of Kin_____
Relationship_____
Phone no_____

Source of information
Media ( )Radio ( )TV ( )Newspapers ( )Internet ( )
Community outreach / Religious outreach……..
Community-based Organization…. ☐
Health workers …….. ☐
Previous Fistula Client…… ☐
Hospital Referral…… ☐
If referred, Source:
_____
Referral Letter: Yes ☐ No ☐

Transportation to facility
☐me spent from home to the facility ____Hours
☐ansport Cost for the Client only _____Naira

How did this condition happen? Did it follow
Labor & Delivery …… ☐
Female Genital Mutilation ….. ☐
Sexual Violence ……. ☐
Trauma …….. ☐
Iatrogenic …….. ☐
Others (specify): _____

Complaints- What are you incontinent of?	**How long have you been leaking?**
Leaking Urine only ☐ Leaking Stool only ☐ Leaking Both Urine & Stool ☐ Others: _____	

APPENDIX T: FC+ AT ISOFS & IOFWG

Submitted Abstracts to ISOFS[34]

	Title	Country	First Author	Accepted
1	Meeting Fistula Clients' Health Care Needs Through Community-based Fistula Diagnosis Events	Bangladesh	F. Akhtar	Oral
2	Source of Injury in Iatrogenic Fistula Cases in Bangladesh	Bangladesh	N. Huda	Oral
3	Iatrogenic Fistula: Needs Urgent Attention	Bangladesh	S. Akhter	Oral
4	Ending Fistula Within a Generation: A Challenge for Bangladesh	Bangladesh	S. Akhter	Oral
5	Community screening for fistula using a 4-question checklist in Bangladesh	Bangladesh	V. Tripathi	Oral
6	Impact de la Fistule Sur La Vie Sexuelle Des Femmes Hôpital Saint Joseph Kinshasa, République Démocratique Du Congo	DRC	Bukabau Babuya Ruth	Oral
7	Task shifting and competency-based training: a preliminary model for physiotherapy capacity building in women's health	DRC	L. Keyser	Oral
8	Iatrogenic fistula – emerging evidence and a call for action	Global	V. Tripathi	Oral
9	Capacity and demand for pelvic organ prolapse services at fistula treatment centers	Global	V. Tripathi	Oral
10	Women still at risk during pregnancy and childbirth post-repair of obstetric fistula: evidence from a prospective follow-up study in Guinea	Guinea	A. Delamou	Oral
11	Recurrence post-repair of female genital fistula in Guinea: results from a prospective follow-up study	Guinea	A. Delamou	Oral
12	Conservative treatment of obstetric fistula: a quick review from supported facilities in Nigeria	Nigeria	A. Isah	Oral
13	Mortalities in Fistula Facilities: Engaging Quality Assurance and Surgical Safety Culture	Nigeria	A. Isah	Oral
14	Record review of fistula cases in Nigeria	Nigeria	E. Arnoff	Oral
15	Exploring the Awareness of Obstetric Fistula Onset and Availability of Fistula Care in Easter and Northern Nigeria	Nigeria	E. Nwala	Oral
16	Findings from a qualitative assessment of communication needs for fistula prevention and treatment in Nigeria	Nigeria	V. Tripathi	Oral
17	A 6 Years' Experience of Managing Obstetric Fistula in Hoima Regional Referral Hospital	Uganda	F. Acheng	Oral
18	Improving Partograph Use and Documentation Among Health Workers on Maternity Ward of Bwera District Hospital in Kasese District Uganda	Uganda	A. Masika	Oral
19	Reducing the Fistula Burden in Kitovu Hospital through Community Mobilization and Treatment	Uganda	C. Kisekka	Oral
20	The Mainz-Ii Rouch- A Viable Option For The Incurable Obstetric Fistula In A Low Income Setting	Uganda	F. Kirya	Oral
21	Adopting the routine treatment model in a public health facility setting in Uganda (Hoima regional referral hospital)	Uganda	I. Asiimwe	Oral
22	A Church's Contribution to Ending Obstetric Fistula:The experience of Nyaigana Archdeaconry	Uganda	M. Kahwa	Oral

[34] Draft list – final FC+ contributions will be provided in FY16-17 Semi-Annual Report based on final ISOFS and IOFWG programs.

Submitted Abstracts to ISOFS[34]

	Title	Country	First Author	Accepted
23	Reproductive intentions among women treated for obstetric fistula – A case study from two treatment sites in Uganda	Uganda	M. Tumuusime	Oral
24	A Retrospective Review Of Obstetric Fistula Repairs At Jinja Regional Referral Hospital	Uganda	N. Angella	Oral
25	Infertility Among Survivors of Obstetric Fistula, A Retrospective Analysis of Fistula Survivors at A Fistula Treatment Facility in Rural Uganda	Uganda	N. Florence	Oral
26	Amidst Underlying Poverty: Exploring Financial, Transportation, and Opportunity Costs Associated with Fistula Management and Repair in Nigeria and Uganda	Global	E. Nwala	Oral
27	Influence of Psychological, Social, Cultural, and Gender Dynamics on Women's Decisions to Seek Fistula Repair in Nigeria and Uganda	Global	P. Sripad	Oral
28	Les defies que recontrent les femmes reparees des FUG-DB: Cas de Kongolo et Kabalo en RDC	DRC	C. Amisi	Poster
29	Les fistules urétéro-vaginales d'origine obstétricale : le profil épidémiologique, les circonstances d'accouchement, les éléments diagnostics et thérapeutiques Hôpital Saint Joseph Kinshasa, République Démocratique du Congo	DRC	D. Nembunzu	Poster
30	Using results from a site survey to build physiotherapy capacity for women's health in Democratic Republic of Congo and Nigeria	DRC	L. Keyser	Poster
31	Investigating the use of manual therapy and vaginal dilators for treatment of vaginal stenosis and fibrosis: a case example	DRC	L. Keyser	Poster
32	Randomised trial of 7-day versus 14-day postoperative bladder catheterisation of simple female genital fistula in Guinea: four years follow-up outcomes in Guinea	Guinea	A. Delamou	Poster
33	Surgical Safety Training Program in Fistula Care	Nigeria	A. Amodu	Poster
34	Pregnancy and childbirth after repair of obstetric fistula in sub-Saharan Africa: A scoping review	Regional	A. Delamou	Poster
35	Village Health Teams – a cradle for family planning access –the experience of two communities in rural Uganda	Uganda	M. Tumusiime	Poster
36	Assessing Level of Utilization of Partograph in Prevention of Obstetric Fistula in Hoima Regional Referral Hospital	Uganda	F. Acheng	Poster
37	Guidelines for management of women living with fistula deemed incurable: efforts from Nigeria	Nigeria	A. Isah	

Plenary Sessions at ISOFS

Session Title	Speaker
Conservative Management of Intractable Incontinence	Jessica McKinney
Fighting for Global Pelvic Floor Care for Patients with Fistula: The Fistula Care Plus Project	Lauri Romanzi

Chaired Parallel Sessions at ISOFS

Session Title	Chair
Prevalence/Epidemiology Studies	Bethany Cole
Untitled	Lauri Romanzi
Evaluation/Treatment Outcomes/Quality of Care	Habib Saduaki
Inoperable Fistula	Lauri Romanzi
Innovations for Fistula Deemed Irreparable	Habib Saduaki
Policy/Public Health/Programming	Sayeba Akhter
Untitled	Lauri Romanzi
Mentoring, Monitoring and Evaluation of Service	Adamu Isah

Sessions at ISOFS

Session Title	Speakers
Fistula Care *Plus* Updates on 5 Program Objectives: 1) Public Private Partnerships in the Fistula Community of Practice (CoP) 2) The role of CBOs in facilitating UNFPA mandate to end fistula within a generation – How do communities understand the spectrum of risk of prolonged/obstructed labors specifically and risks of non-SBA delivery in general? 3) Mobile technology and other innovations for fistula screening and referral 4) Global Surgery CoP – Key component towards ending fistula within a generation 5) Standardizing M&E indicators for fistula programs	Lauri Romanzi Amina Bala Vandana Tripathi Bethany Cole

APPENDIX U: 2016 INTERNATIONAL DAY TO END OBSTETRIC FISTULA FC+ ACTIVITIES

Global Team

To commemorate International Day to End Obstetric Fistula, the Global Team built on momentum created by international meetings taking place around 23 May, including Women Deliver and the World Health Assembly. FC+ worked with the EngenderHealth Communications Team to create an IDEOF Communications Toolkit to assist in external communications leading up to and throughout all events.

Women Deliver: Fistula Care *Plus* coordinated two events at the Women Deliver conference, held May 16-19 in Copenhagen, Denmark.

- "**The Forgotten Challenge: Maternal and Newborn Morbidity**" This concurrent session held on Wednesday, May 18, focused on what health systems must deliver to reduce maternal and newborn morbidity, including a discussion of effective management of prolonged/obstructed labor. Participants included: Dr. Lauri Romanzi, FC+; Dr. Hannah Blencowe, LSHTM; Ruma Khatun, BRAC/DFID Midwifery Program; Dr. Charlemagne Ouedraogo, University of Ouagadougou. During the question and answer portion, Erin Anastasi of UNFPA's Campaign to End Fistula announced publicly for the first time the theme for this year's IDEOF, "Ending Fistula Within a Generation."

Figure 2 Women Deliver participants during the FC+ coordinated panel on maternal and newborn morbidities.

- "**Safe Surgery: A Non-Negotiable for Women's Health, Equity, and Wellbeing?"** A breakfast event was held on Thursday, May 19, from 7-8 AM in collaboration with G4 Alliance, GE Foundation, and Safe Surgery 2020. The event featured Dr. Denis Mukwege of Panzi Hospital (recently named one of *TIME*'s 100 Most Influential People); Erin Anastasi, UNFPA Campaign to End Fistula; Dr. Luc de Bernis, formerly of UNFPA; Dr. Lauri Romanzi, EngenderHealth. Participants explored the intersection of safe surgical care (including maternity care and fistula surgery) and women's well-being, economic productivity, and equality. Afterwards, participants were interviewed by the press. Building on the success of the event, Dr. Denis Mukwege and EngenderHealth President and CEO Ulla Muller co-authored an article for Huffington Post.

World Health Assembly: FC+ Director Lauri Romanzi attended the 69th World Health Assembly as a delegate alongside G4 Alliance, and participated in an event on global surgery held on 23 May.

Social Media:

- Lindsay Mallick of the DHS Program authored a blog on recent research related to the link between fistula and gender based violence, carried out in collaboration with Vandana Tripathi of FC+ Global Team. The blog was cross-posted on the FC+ webpage, promoted on social media. FC+ also coordinated blog's cross-posting to MHTF Blog.
- FC+ participated in the #FistulaDay twitter chat hosted by Kupona Foundation and J&J Global Health. Twitter metrics for the entire period covering Women Deliver and IDEOF are below.

Twitter Metrics for period of May 14-24, 2016 Women Deliver and IDEOF		
	Previous date range	**May 14-24**
Twitter Followers	358	**389**
New Followers	12 (3.5% increase)	**28 (7.8% increase)**
Impressions (number of times our tweet or a mention of us could have appeared in other feeds)	16,530	**27,141**
Total Engagements	134	**366**
Link clicks	25	**29**
Retweets	25	**132**
Favorites/Likes	33	**107**
Mentions	24	**46**
Overall engagement increase/decrease	Increase of 54% since previous date range	**Increase of 185.9% since previous date range**

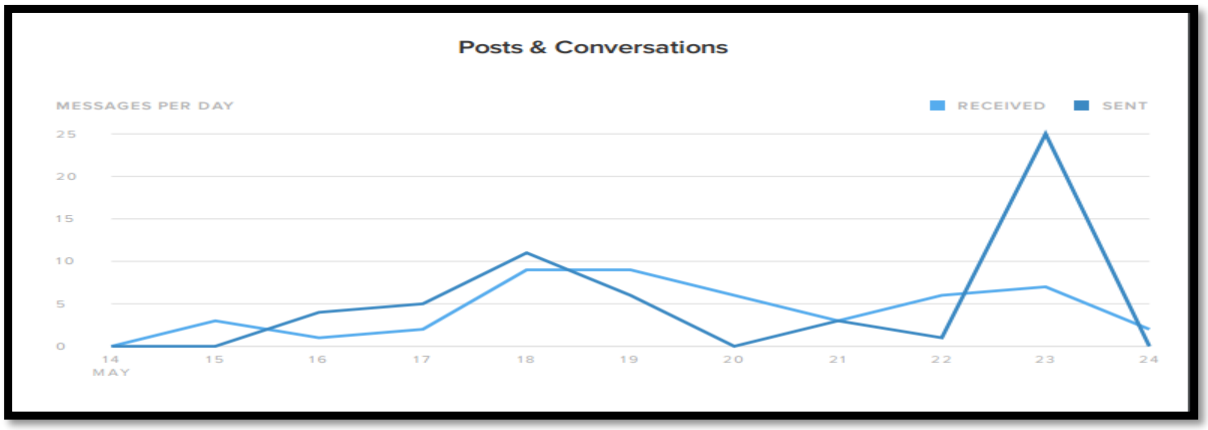


Figure 3 Graph showing metrics of Twitter messages sent and received for period of May 14-24, covering both Women Deliver and IDEOF.

Bangladesh

Fistula Care *Plus* Bangladesh and our partner organizations hosted the following events to commemorate IDEOF, which were guided by prior discussions at the meeting of the National Fistula Task Force:

1. **Production of two audio talks on prevention and care of fistula:**

FC+/Bangladesh produced two 25-minute audio talks for community radio stations. Senior fistula surgeons and OB/GYNs, the Secretary General of Obstetrical and Gynecological society, academics, TV personalities, and Ministry officials joined the talk shows. Overall, 14 radio stations broadcast the

talks on May 23 and 24. BBC and VOA affiliated FM radio stations broadcasted interviews and stories on fistula.

A workshop on fistula communication was organized by FC+ at the University Fistula Center and linked to the airing of these audio talks. Professionals from 14 radio stations joined the workshop, where a handbook on fistula communication for community radio managers was launched. Ten media persons working with daily newspapers and television centers also join the workshop. As an outcome, 7 newspapers including 2 national dailies ran editorials on Fistula Care *Plus* activities alongside information on prolonged obstructed labor. Additionally, two television centers telecasted special program reflecting FC+ activities.

Figure 4 Unveiling and distribution of Audio CD on Fistula for airing through Community Radios

Print

- The Daily New Age, Editorial on Female Genital Fistula,
- Article on Female Genital Fistula in 7 newspapers: The Daily News Today; The Daily Sangbad; The Daily Manabzamin; The Daily Inqilab; The Daily Nayadiganta; The Daily Inqilab; The Daily Ittefaq

Radio

- BBC Bangla Probaho, Interview of Dr. Abu Jamil Faisel and Dr. Sk Nazmul Huda. Coverage 160 million.
- BTV, Interview of Dr. Sk Nazmul Huda, CPM, FC+, Coverage-160 million.
- VOA, Interview of Dr. Sk Nazmul Huda, CPM, FC+, EHB, Coverage-16 million.
- Boishakhi TV, Interview of Dr. Abu Jamil Faisel, CR, EHB, Coverage-100 million.
- Radio Sagordwip, Talk Show on Female Genital Fistula, Coverage-2 million.
- Radio Chilmari, Talk Show on Female Genital Fistula, Coverage- 2 million
- Radio Mahananda, Talk Show on Female Genital Fistula, Coverage-2 million.
- Radio Borendra, Talk Show on Female Genital Fistula, Coverage-2 million.
- Radio Mukti, Talk Show on Female Genital Fistula, Coverage-2 million.
- Radio Jhenuk, Talk Show on Female Genital Fistula, Coverage- 2 million.
- Radio Sundarban, Talk Show on Female Genital Fistula, Coverage- 2 million
- Radio Lokobater, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Bikrampur, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Pollikantho, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Sagorgiri, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Naf, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Sagabela, Talk Show on Female Genital Fistula, Coverage-2 million
- Radio Padma, Talk Show on Female Genital Fistula, Coverage-2 million

2. **Fistula Day celebration at Kumudini Hospital**: A seminar on fistula was organized by Kumudini Hospital to mark the International Day to End Obstetric Fistula 2016 on May 25, 2016. Ms. Marietou Satin, Deputy Director, USAID/Dhaka and two urogynecologists from Pacific Command (PACOM) of US army joined the seminar which was attended by over 200 doctors and nurses.
3. **Fistula Day Celebration at the University Fistula Center, Bangabandhu Sheikh Mujib Medical University:** To mark IDEOF, the fistula surgeons of BSMMU and visiting surgeons from USA greeted fistula patients in the hospital on May 26, 2016. UFC also distributed food among the fistula patients in other hospitals of Dhaka.
4. **Fistula Day celebration at Ad-din Hospital Khulna:** International Fistula Day and International Safe Motherhood day was jointly celebrated at Ad-din Akij Medical College, Khulna on May 28, 2016. Visiting surgeons from USA spoke on the occasion about the importance of safe maternity care. Ms. Marietou Satin of USAID/Dhaka also join the event which was attended by 120 doctors and nurses.
5. **Fistula day celebration at National Fistula Center:** Fistula Care *Plus* jointly organized a seminar and live fistula surgery demonstration for trainee surgeons at the National Fistula Center on June 4, 2016. Professor Dr. Shahla Khatun, Prof. Sayeba, and 200 doctors and nurses joined the event.

DRC

MSRK celebrated International Day to End Obstetric Fistula with an event at the center. A family dinner was served to all of the clients and staff following the commemoration.

Figure 5 IDEOF commemoration event at MSRK.

IGL commemorated IDEOF with a parade through Beni, led by a brass band and carrying informative banners. The march culminated at the IGL facility, where speeches were made by facility staff and key stakeholders highlighting the intensified efforts to end fistula in DRC. Following the event, all participants gathered for a meal.

St. Josephs The Fistula Care *Plus* project at St. Joseph's hospital, in collaboration with UNFPA, support the Ministry of Health to commemorate International Day to End Obstetric Fistula on Monday, 23 May. The event was held at CEPAS center. Just over 400 people were present at the event, mainly medical and nursing students, university professors, midwives, members of NGOs, and members of civil society.

Following the national anthem, speeches were made by the Director of the NRHP as well as a UNFPA representative. This was followed by a skit on early marriage and early pregnancy performed by the theater group CECU. Presentations were made by Prof Punga, Chief of Urology at the University of Kinshasa, on the epidemiology of fistula and by Dr. Dolores Nembunzu, FC+ Project Manager at St Joseph Hospital on the work of FC+ at St. Josephs. A fistula client joined the event to share her experience and describe how she was able to

access care at the facility. The Secretary General for Health closed the event with a speech, before all attendees joined together to since the Congolese national anthem. The event was followed by refreshments. As members of the media were present, FC+ DRC looks forward to seeing highlights reported in the coming weeks.

Nigeria

Nigeria commemorated 23 May with a special focus on the media. Below is a list of radio, television, and print publications where FC+ staff appear.

Radio

- FC+ hosted a nationwide program on Radio Nigeria on the topic of "Giving Birth: A Struggle between Life and Death among Women of Reproductive Age." Participants included: Professor Oladosu Ojengbede, Consultant Gynecologist and President-elect of ISOFS; Professor Sunday Adeoye, Medical Director of National Obstetrics Fistula Center (NOFIC) Abakaliki; Dr. Emmanuel Yakubu Consultant Gynecologist NOFIC Abakaliki; Mrs. Nwaofe Veronica, Chief Matron/Family Planning Provider, NOFIC Abakaliki; Dr. Habib Sadauki, Country Project Manager FC+; Olajumoke Adekogba RH/FP Advisor FC+.
- Two broadcasts on Express FM radio in Kano featuring Dr. Habib.
- Dr. Steve Aragidi, formerly of Sobe Specialist Hospital and now with the FMOH, participated in a radio program for Radio Kwara.
- In Sokoto, the commissioner for health, the commissioner for women affairs and the Medical Director of Maryam Abacha Fistula Hospital hosted a live call-in radio program at 8am on Rima Radio AM.
- At 4pm on May 24, a live call-in radio program was held on Vision FM. FC+ staff, the Commissioner for Health, as well as repaired fistula client participated. The client also discussed the impact FGC/M had on her reproductive health and her experience with fistula.
- FC+ staff, providers, and a client at Gesse Fistula Center participated in a Saturday morning Hausa language live call-in show on Kebbi State Radio.
- In Jigawa, the FC+ supported CBO VILDEV conducted a Hausa broadcast phone- in radio program (Barka da Hantsi) between 8-9am on the 23rd May 2016. Participants include the deputy director of hospital services and CBO representatives.
- Radio Link Program- FC+ participated at this two-hour national call-in radio show on the platform of Radio Nigeria in Abuja on 4th June 2016. Featured on the program were Her Excellency Dr. Amina Abubakar Bello, the Wife of the Executive Governor of Niger State; Professor Oladosu Akambi Ojengbede, President Elect ISOFS; Dr. Mrs. Binyerem Ukaire, Head of Fistula Desk, Federal Ministry of Health; Dr. Habib Sadauki, FC+ Country Project Manager; Ms. Nene Afuekwe Adesua, a successfully repaired fistula client and advocate. Several text messages, emails and phones calls were received during this live show. The audio file will be made available on the FC+ website.

Figure 6 Photo at Radio Link Program in Abuja on 4th June 2016

TV

- Dr. Adamu Isah was featured on an evening Rima TV program, broadcast from Sokoto.
- Program Officer Ebere Diokpo was interviewed for a news broadcast which aired on the evenings of May 23 and 24 on NTA channel.

Print

- RH/FP Advisor Olajumoke Adekogba was featured in an article in the Vanguard: http://www.vanguardngr.com/2016/05/family-planning-safe-women-dr-jumoke-adekogba/
- Dr. Habib Sadauki was featured in the article on Daily Trust: UN champions efforts to end fistula in a generation – By Judd-Leonard Okafor | Publish Date: May 24 2016
- Dr. Suleiman Zakariya was featured in the article on National Mirror: More child brides developing VVF. May 25, 2016
- Cross River promises 80 patients free surgery to mark World VVF Day, National Daily 23rd – 28th May 2016
- The Nation Newspaper published article on Jigawa commemorations on May 24
- Leadership Hausa published article on Jigawa commemorations on 27th May

In addition to raising awareness using media, the FC+ Nigeria team visited Gesse Fistula Center in Birnin Kebbi, Kebbi State for an event commemorating 23 May. The facility had just finished a week long pooled-effort campaign in honor of IDEOF, where 50 women received fistula surgery. FC+ Country Program Manager Dr. Habib Sadauki, Deputy Manager Dr. Adamu Isah, and other members of FC+ Nigeria and Global Team were present in Kebbi for the event. The Acting Permanent Secretary of the State Ministry of Health (SMOH), the SMOH FP Coordinator, and SMOH Director of Pharmaceutical Services also joined to hand over needed hospital equipment, including mattresses and family planning commodities, alongside FC+.

On May 24, FC+ visited supported site Maryam Abacha Fistula Hospital in Sokoto to support the State Commissioner for health to commission fistula and FP commodities. FC+ also coordinated with the First Lady of Sokoto State, who visited Maryam Abacha facility later in the week and made her own donations.

Town hall meetings were also conducted in Jigawa and Zamfara states to mark the day. Below are some of the pictures. The Honorable Commissioner Ministry of Women Affairs and Social Development, Jigawa State, Hajiya Ladi Dansure recognized the efforts made by local CBO VILDEV and FC+/Nigeria during the town hall. After the meeting, a visit was paid to Jahun VVF center where new wrappers were presented to each fistula client. Jigawa TV (JTV), NTA, Dutse, Radio Jigawa, and Freedom Radio representatives attended the meeting.

Figure 7 Townhall meeting in Jigawa State.

Uganda

FC+/Uganda commemorated IDEOF on May 23 in Arua District. Arua District is located in the northwest of Uganda, West Nile Region, about 425km from Kampala. The day was preceded by an obstetric fistula screening and surgical treatment camp at Arua Regional Referral Hospital the prior week, where FC+

supported the participation of three fistula surgeons. FC+ also provided t-shirts to participants from the Arua nursing school, Arua primary school, and to women groups that took part in the commemoration march around Arua town and surrounding communities on the 23rd. At the event, EngenderHealth was represented by the Senor Medical Associate, the Program Associate for Community Engagement, the Front desk administrator, and the transport staff.

Figure 8 Fistula march in Aura Town, led by a brass band.

Among the many invited guests to the event were: the outgoing Minister of Health of the Government of Uganda, Dr. Sarah Achieng Opendi; the Commissioner in charge of Clinical Services and the MOH, Dr. Jacinto Amandua; newly elected members of Parliament; district leaders; the community at large. Dr. Jacinto Amandua thanked EngenderHealth and all development partners for the support to the MOH, and expressed gratitude to development partners UNFPA, WAI, and TERREWODE for the great work done to increase the capacity of most regional hospitals to carry out fistula prevention and treatment services. Attending politicians then made pledges including: to create a fistula desk at their offices, to contribute part of their salaries to support fistula services at Arua Hospitals, and to support the mobilization of women for prevention and treatment services.

Figure 9 Guest of Honor, the Honorable Dr. Sarah Opendi, adresses guests.

Honorable Dr. Sarah Opendi outgoing Minister of Health of Uganda, joined the rest in recognizing the efforts made by the development partners in supporting fistula repair work. She also took time to teach the politicians what their role was in this fight against fistula. She hinted on baby steps achieved in the fight of obstetric fistula, and the competing government needs that sometimes derails these efforts. She reminded the district politicians that they had money in the budget to convene meetings related to monitoring of fistula services and encouraged them to convene these meetings before the financial year end. She drove home the message that dedication is needed by all stakeholders by reminding everyone that some women from neighboring districts were eager to receive treatment and walked miles by foot, and how we should meet their determination. Other topics that the Minister covered included: the first fistula camp hosted in Arua, sponsored by AMREF; the importance of avoiding early marriages; involving men, Village Health Teams, and religious leaders in solutions including prevention and mobilizing clients; family planning as a key to prevention; the need for change of religious and cultural attitudes towards RMNCH care seeking behaviors and strengthened referral systems; the challenge of health worker staffing at all levels.

West Africa Region/Niger

IDEOF activities in Niger launched on May 27 in order to accommodate the schedule of participating politicians. A "conference debate" on fistula prevention was held on Friday May 27th and was widely covered by national media. Over 200 participants attended, among them physicians, midwives, nurses and government officials.

Figure 10 Panelists at the 23 May commemorative event in Niamey.

On Friday, June 03, the First Lady of Niger Dr. Malika will host a "Special Day" at CNRFO in Niamey. She will visit with clients and provide a donation to the facility. This will be followed by a "Table Ronde" for fundraising to finance the implementation of the National Fistula Strategy, which FC+ has supported through review and updates.

APPENDIX V: FC+ CORE INDICATORS: ANNUAL ACHIEVEMENTS

Note: Benchmarks for FY 15/16 are the approved benchmarks based on approved country workplans. Benchmarks for FY 17/18 are drawn from the original project approved FC+ PMP. Blanks indicate indicators/years for which benchmarks have not been finalized.

Goal: To strengthen health system capacity for fistula prevention, detection, treatment, and reintegration in priority countries in Sub-Saharan Africa and South Asia.

Indicator 1: Number of countries supported by Fistula Care *Plus* (FC+)

Definition: # of countries in which FC+ is supporting fistula repair sites and other activities to strengthen fistula-related policy, community capacity, and services

Additional description/context: FC+ will support countries to strengthen capacity for obstetric fistula prevention, detection, repair, and reintegration of affected women.

Data source and collection: Collected quarterly from project reports by FC+ staff

Benchmark Values[35]

Year	*Target*	*Actual*	*Notes*
FY2013/14	5	**5**	
FY2014/15	5	6	FC+ has supported activities in Togo through the USAID/WARP mission
FY2015/16	**6**	**6**	FC+ has supported activities in Togo through the USAID/WARP mission
FY2016/17	6		
FY2017/18	7		

Indicator 2: Number of sites supported by FC+ for fistula repair and prevention

Definition: # of facilities to which FC+ is providing support for fistula repair services.

Additional description/context: FC+ will support facilities to provide fistula repair services. The majority of these sites will also provide some level of prevention care. Support can include: provider training and clinical mentoring, equipment, and/or other site strengthening activities such as quality improvement (QI) and management capacity building. Support to clients at these sites can include: transport costs to hospitals for surgery, temporary shelter, costs for repair, post-operative hospitalization costs, pre and post operative counseling. and client rehabilitation services during post-operative recovery. Supported sites will provide data to FC+ on clinical indicators including numbers of clients seeking and requiring fistula repair services, the number of repairs performed, and the outcomes for those clients. Supported sites may also be engaged in fistula prevention activities, as

[35] Benchmarks are aggregated for all indicators unless otherwise stated.

defined in indicator 3. However, in reporting, sites will be disaggregated into prevention-only sites and repair/prevention sites. Sites that provide both are reported via indicator 2.

Data source and collection: Collected quarterly from project reports by FC+ project staff and in-country partners

Benchmark Values

Year	*Target*	*Actual*	*Notes*
FY2013/14	26	25	USAID also supported treatment sites in Tanzania and DRC (one) through bilateral projects.
FY2014/15	32	31	
FY2015/16	**34**	**37**	
FY2016/17	36		
FY2017/18	36		

Indicator 3: Number of prevention-only sites supported by FC+

Definition: # of facilities to which FC+ is providing support only for fistula prevention services.

Additional description: FC+ will support facility sites to provide services that prevent fistula. Support can include: include provider training and clinical mentoring, equipment, minor renovation or rehabilitation of facilities, other site strengthening activities such as quality improvement (QI) and management capacity building; and/or community outreach for awareness, screening, detection, and referral activities. FC+ will focus prevention interventions in three areas: a. Emergency obstetric services (EmOC) with immediate interventions to help prevent fistula. We will track three key immediate term interventions which will be a focus of strengthening at selected sites:

- Correct use of the partograph to manage labors
- Availability of C-section services
- Routine use of catheterization for women who had prolonged/obstructed labor.

b. Family Planning (FP) services as a medium term fistula prevention intervention

c. Screening, detection, and referral of women needing fistula treatment to repair sites.

As noted above, facilities will be classified as either prevention-only or repair/prevention sites. Repair sites may also be engaged in any or all of the prevention activities outlined here.

Data source and collection: Collected quarterly from project reports by FC+ staff and in-country partners

Benchmark Values

Year	*Target*	*Actual*	*Notes*
FY2013/14	43	16	Delays in funds release and subaward agreements negatively affected prevention-only site support

FY2014/15	39	749	FC+ has temporarily taken on support of a large number of prevention-only sites in Nigeria following the close of the TSHIP project.
FY2015/16	**790**	**789**	
FY2016/17	791		
FY2017/18			

Objective 1: Strengthened enabling environment to institutionalize fistula prevention, treatment and reintegration in the public and private sectors

Indicator 4: Number of countries receiving support from FC+ where governments or supported facilities have revised/adopted/ initiated/implemented policies or guidelines for fistula prevention or treatment

Definition: # of supported countries or facilities (some private sites may develop their own policies/guidelines) that have revised/adopted, initiated, or are continuing to implement policies in support of fistula prevention and treatment services.

Additional description/context: The FC+ Annual Report will include the name of policy/guideline, location, and status (e.g., under development or review, approved, implemented). Fistula-specific polices or guidelines can be part of broader reproductive and/or maternal health documents. For the purposes of FC+, a policy[36] is an official statement by a government or health authority that provides an overall direction for a health issue by defining a vision, values, principles, and objectives, and establishing a broad model of action to achieve that vision. Policies may address financing, coordination among agencies and programs, necessary legislation, organization of services, procurement of material resources, required human resources, quality standards, and/or information systems. A guideline is a statement that provides a framework or course of action through which to implement policy objectives, including recommendations and best practices that ensure quality within services to be provided. This indicator includes countries that have fistula policies/guidelines in place at the start of the project.

Data source and collection: Collected annually from project reports and policy/guideline documents by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	5	5	
FY2014/15	5	5	
FY2015/16	**6**	**5**	
FY2016/17			

[36] Adapted from World Health Organization definitions. Available at: http://www.who.int/mental_health/policy/services/1_MHPolicyPlan_Infosheet.pdf. Accessed January 22, 2014.

FY2017/18	7		

Indicator 5: Number of countries receiving support from FC+ where governments or supported facilities have addressed WDI, women with TF and/or POP in their fistula and/or broader reproductive/maternal health policies or guidelines

Definition: # of supported countries or facilities (some private sites may develop their own policies/guidelines) that have addressed the needs of WDI, women with TF, and/or women with POP in their relevant policies/guidelines.

Additional description/context: This incorporation can be within fistula-specific documents or broader policies/guidelines on reproductive and/or maternal health services.

Annual report will include the name of policy/guideline, location, and status (e.g., under development or review, approved, implemented). The definitions of policies and guidelines described under indicator 5 will be applied here.

Data source and collection: Collected annually from project reports and policy/guideline documents by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	0	0	Policy efforts related to WDI/TF/POP to begin in FY14/15
FY2014/15	**1**	**2**	Nigeria and Uganda have both held national level meetings drafting policy related to treatment and reintegration of WDI
FY2015/16	2	2	Bangladesh and Niger
FY2016/17			
FY2017/18	4		

Indicator 6: Number of countries receiving support from FC+ in which governments have budget line item for fistula care

Definition: # of supported countries with a specific annual budget allocation to fund fistula prevention, detection, repair, and/or reintegration services.

Additional description/context: This is an annual, rather than aggregated, indicator.

Data source and collection: Collected annually from project reports and key informant interviews by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	2	2	Budget allocations made in Nigeria and Uganda

FY2014/15	2	2	Budget allocations made in Nigeria and Uganda
FY2015/16	**3**	**2**	Bangladesh and Nigeria
FY2016/17			
FY2017/18	5		

Indicator 7: Number of countries with fistula indicators included in the health management information system (HMIS)			
Definition: # of supported countries whose HMIS includes fistula indicators.			
Additional description/context: The primary indicator of interest is the number of fistula repairs; however, additional relevant indicators that may be incorporated into HMIS include the number of women identified as needing repair.			
Data source and collection: Collected annually from project reports and key informant interviews by FC+ staff and in-country partners			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	4	3	Along with Niger, Nigeria, and Uganda, indicators have also been approved in a 4th country (Bangladesh), but data collection has not yet begun.
FY2014/15	4	3	See FY13/14
FY2015/16	**4**	**4**	Bangladesh, Niger, Nigeria, Uganda
FY2016/17	4		
FY2017/18	5		

Indicator 8: Number of public/private partnerships established to address fistula prevention, repair, or reintegration by country			
Definition: # of public/private partnerships established to address country-level needs related to fistula prevention, repair, and/or reintegration.			
Additional description/context: Partnerships may include the leveraging of private (e.g., corporate) financial resources to fund fistula activities and/or the provision of in-kind support to enable fistula services (e.g., medical equipment, drugs, supplies, human resources).			
Data source and collection: Collected semi-annually from project reports by FC+ staff and in-country partners			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**

FY2013/14	1[37]	3	In addition to the 3 PPPs (Bangladesh, Nigeria, and Uganda), an individual has also donated commodities in Uganda
FY2014/15	2	3	Partnerships for private contribution to fistula activities are active in DRC, Nigeria, and Uganda. Proposals for such partnership are pending in Bangladesh and Niger.
FY2015/16	**3**	**4**	Bangladesh, DRC, Nigeria, Uganda
FY2016/17			
FY2017/18	7		

Objective 2: Enhanced community understanding and practices to prevent fistula, improve access to fistula treatment, reduce stigma, and support reintegration of women and girls with fistula

Indicator 9: Number of community volunteers/educators trained in tools and approaches to raise awareness regarding fistulae prevention and repair

Definition: # of community volunteers/educators trained in topics and approaches and approaches, such as social and behavior change communication (SBCC), stigma, gender-based barriers, and male involvement to mobilize communities for fistula prevention, the use of safe motherhood services including family planning and EmOC, and fistula screening/detection/referral for repair.

Additional description/context: Community volunteers/educators are individuals affiliated with or employed by community-based organizations, non-governmental organizations, and/or faith-based organizations. In some countries, they are affiliated with government agencies (e.g., Ethiopia's Health Development Army); however, while these individuals may liaise with health facilities and providers, their role is restricted to health promotion and they are **not** formally attached to specific health facilities. These are considered to be distinct from the community health workers discussed in Indicator 18 below.

Data source and collection: Collected quarterly from training reports by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	227	0	Delays in funds release and subaward approvals negatively affected ability to implement community volunteer/educator trainings in FY13/14
FY2014/15	494	776	

[37] This will be achieved in Y2 due to the shortened Y1.

FY2015/16	**607**	**679**	
FY2016/17	725		
FY2017/18	1,100		

Indicator 10: Number of community awareness-raising activities/events conducted by program partners			
Definition: # events carried out by program partners to provide information about EmOC availability, fistula prevention, screening and detection, repair, and other safe motherhood issues.			
Additional description/context: Events may include community gatherings and broadcast messages.			
Data source and collection: Collected quarterly from program monitoring reports by FC+ staff and in-country partners.			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	570	12	Delays in funds release and subaward approvals negatively affected ability to implement community outreach and education in FY13/14.
FY2014/15	586	1,990	
FY2015/16	**1,695**	**10,393**	
FY2016/17	6,130		
FY2017/18			

Indicator 11: **Number of participants reached through community awareness-raising events/activities conducted by program partners**			
Definition: # of participants reached through community awareness raising events/activities conducted by program partners.			
Additional description/context: Participants may include attendees at events in the community, as well as those listening to/watching broadcast messages. Numbers of persons reached will be estimates for some activities; e.g., radio partners will provide estimates of the listenership for broadcast events.[38]			
Data source and collection: Collected quarterly from program monitoring reports by FC+ staff and in-country partners.			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**

[38] FC+ has expanded its definition of the reach of community activities to include the audience for radio broadcasts; not all countries have been able to establish baseline estimates of these audiences yet; these benchmarks may thus be revised based on Y1 experience.

FY2013/14	155,150	10,745	Delays in funds release and subaward approvals negatively affected ability to implement community outreach and education in FY13/14
FY2014/15	232,100	414,067	
FY2015/16	**In person: 306,750** **Mass media: 1,550,000**	**In person: 2,862,124** **Mass media: 3,676,406**	
FY2016/17	In person: 327,000 Mass media: 102,150,000		
FY2017/18			

Objective 3: Reduced transportation, communication, and financial barriers to accessing preventive care, detection, treatment, and reintegration support

Indicator 12: Number and type of transportation initiatives introduced, enhanced, and/or tested			
Definition: # of initiatives introduced enhanced, and/or tested to reduce barriers faced by women in traveling to fistula services, particularly repair, in the catchment areas of FC+ sites.			
Additional description/context: Initiatives may include vouchers, support from local transportation networks, and other strategies to enable transportation to fistula services.			
Data source and collection: Collected semi-annually from program monitoring and evaluation reports by FC+ staff and in-country partners			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	0	0	
FY2014/15	2	0	Delays in approvals/conduct of Pop Council study have negatively impacted ability to move forward with designing and piloting initiatives
FY2015/16	**2**	**0**	Initiatives planned but not yet implemented, will take place in FY16/17
FY2016/17	2		
FY2017/18	4		

Indicator 13: Number and type of communication technologies introduced, enhanced, and/or tested for improving communication with patients and/or providers			
Definition: # of initiatives introduced enhanced, and/or tested to improve communication with providers and/or patients engaged through FC+ sites.			
Additional description/context: Initiatives may target health behavior and service utilization messages for women, follow-up support and mentoring for trained providers, and/or monitoring of service provision/uptake by patients and providers.			
Data source and collection: Collected semi-annually from program monitoring and evaluation reports by FC+ staff and in-country partners			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	0	0	
FY2014/15	1	**0**	Delays in approval and conduct of Pop Council study have negatively impacted ability to design/test new technologies
FY2015/16	**2**	**0**	Initiatives developed but will be implemented in FY16/17
FY2016/17	2		
FY2017/18	4		

Objective 4: Strengthened provider and health facility capacity to provide and sustain quality services for fistula prevention, detection, and treatment

Indicator 14: Number of women requiring fistula repairs			
Definition: # of women diagnosed with obstetric fistula at supported repair sites			
Additional description/context: This will be a subset of women seeking treatment at repair sites; women will be screened to determine whether their incontinence is due to obstetric fistula. This indicator encompasses all types of fistula, including urinary and RVF together, and RVF alone.[39]			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**

[39] We have included this indicator in our approved PMP instead of number of women seeking fistula repairs. We know from experience that many women seeking care are often not diagnosed with fistula, but rather have some other condition that results in some incontinence. FC+ will collect information on the number of women seeking care for urinary incontinence as part of our routine clinical monitoring as was done under Fistula Care. If the difference between the number seeking and the number requiring is large then we will know that work needs to be done to improve messages about fistula treatment. We believe for USAID reporting to Congress, the number requiring is more powerful. We are using the term urinary fistula instead of VVF since it more accurately describes the range of typical fistula cases seen at sites. Urinary type fistula includes: vesicovaginal, urethro-vaginal, uretero-vaginal, vesico-uterine.

FY2013/14	2,131	912	
FY2014/15	4,000	3,790	
FY2015/16	**18,000**	**4,798**	
FY2016/17			
FY2017/18	28,000		

Indicator 15a: Number of surgical fistula repairs			
Definition: # of fistula repair surgeries performed at supported sites.			
Additional description/context: This includes all types of fistula repairs, including urinary alone, urinary and RVF together, and RVF alone. Each time a woman has surgery it will be counted; however, it is unlikely that any woman would get more than one repair surgery per quarter. Therefore the quarterly figure for the number of surgeries should therefore equal the number of women getting fistula repair.			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	1,300[40]	852	Delays in funds release and subaward approvals negatively affected ability to support fistula repairs during FY13/14.
FY2014/15	3.830	2,876	Repairs benchmark increased due to requests from Bangladesh and Nigeria missions
FY2015/16	**4,121**	**3,514**	
FY2016/17	3,780		
FY2017/18	19,000		

Indicator 15b: Number of conservative fistula treatments (catheterization)
Definition: # of conservative fistula treatments (catheterization) performed at supported sites. Note: There is no annual benchmark assigned to this indicator.
Additional description/context: This includes the number of catheterizations performed on an existing fistula, as a conservative approach to fistula repair, provided by supported sites.

[40] Release of MCH funds were delayed in Nigeria and Uganda; these two countries account for a large proportion (73%) of the estimated repairs. This benchmark was calculated based on the provision of repairs for two quarters. However, repairs in Uganda were only carried out in the final quarter of the FY.

Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff.			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	N/A	4	
FY2014/15	N/A	304	
FY2015/16	**N/A**	**323**	
FY2016/17	N/A		
FY2017/18	N/A		

Indicator 16: Outcomes of fistula repair (percentage closed and dry)			
Definition: Numerator: # of women who received any type of fistula repair surgery (urinary alone, urinary and RVF together, and RVF alone) who when discharged, had a closed fistula and were dry at time of discharge / Denominator: # women who had any type of fistula repair surgery and were discharged X 100			
Additional description/context: N/A			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	75%	76%	Closed and continent data is incomplete for FY13/14 due to new data collection tools. Data presented is what is available for this time period.
FY2014/15	75%	67%	79% of fistulas successfully closed (67% closed and continent, 12% closed and incontinent) 21% not closed
FY2015/16	**75%**	**77%**	88% of fistulas successfully closed (77% closed and continent; 11% closed and incontinent) 12% not closed
FY2016/17	75%		
FY2017/18	75%		

Indicator 17: Complications of fistula repair (percent of repairs with complications)

Definition: Numerator: # of women discharged in a quarter whose fistula repair surgeries resulted in a reportable complication / Denominator: total # of women discharged in a quarter following fistula repair surgeries X 100

Additional description/context: Reportable complications can either be major or minor related to the fistula surgery or to anesthesia. As one woman may have more than one complication, the occurrence types of complications will also be disaggregated. Deaths will be monitored separately and reported to USAID annually in a special report. Guidelines regarding complications will be carried over from the Fistula Care Project.

Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	<20%	.4%	
FY2014/15	<20%	2.3%	
FY2015/16	**<20%**	**2.7%**	
FY2016/17	<20%		
FY2017/18	<20%		

Indicator 18: Number of health systems personnel trained, by topic, for fistula and/or POP prevention and treatment (disaggregated by training topic, sex and cadre of provider)

Definition: # of persons attending training in support of fistula services

Additional description/context: Type of training will be reported by the primary training category. Training in surgical repair is included in this indicator, and will be disaggregated. Training will be reported for specific topics such as counseling, use of the partograph, quality improvement, data-driven management, etc.

Categories of health system personnel trained may include:

- Surgeons and other physicians
- Nurses and midwives
- Other non-physician clinicians (e.g., clinical officers)
- Non-clinician counselors
- Facility managers
- Community health workers

For the purposes of FC+, community health workers are individuals formally affiliated with the health system and linked to specific health facilities, generally providing health education and services at the community/household level. This may include both unpaid and paid individuals. This term encompasses cadres known by other titles, depending on the country context (e.g., Ethiopia's Health Extension Workers).

Data source and collection: Collected quarterly from training reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	526	403	Delays in funds release and subaward approvals negatively affected ability to implement training in FY13/14 Number revised from FY13/14 report to reflect additional data submitted from countries post-reporting
FY2014/15	929	1,065	
FY2015/16	**1,395**	**1,414**	
FY2016/17	1,041		
FY2017/18	6,800		

Indicator 19: Number of supported facilities that have introduced treatment for POP			
Definition: # of facilities to which FC+ is providing support that have introduced POP treatment services.			
Additional description/context: Support can include: provider training and clinical mentoring, equipment, minor renovation or rehabilitation of facilities, and/or other site-strengthening activities such as quality improvement (QI) and management capacity building. Supported sites will provide data to FC+ on the number of POP treatment services provided. Some POP facilities may also be providing fistula repair and/or prevention services. In that case, those sites will also be reported in Indicator 2 or 3, as appropriate; this will be disaggregated in the report.			
Data source and collection: Collected semi-annually from program reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	0	0	
FY2014/15	1	0	Sites identified, implementation will begin in FY15/16
FY2015/16	**6**	**4**	
FY2016/17			
FY2017/18	8		

Indicator 20: Number of POP treatment services provided
Definition: # of POP treatment services performed at supported sites.

Additional description/context: This includes both conservative treatment (e.g., treatment with a pessary) and all types of surgical treatment (e.g., hysterectomy with pelvic support repair, mesh, etc.). Reports will disaggregate by type of treatment.			
Data source and collection: Collected quarterly from hospital registers/ client records/program reports by FC+ staff and partner staff			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	0	NA	No sites supported yet
FY2014/15	**30**	NA	No sites supported yet
FY2015/16	**505**	**0**	Support initiated but actual repairs not yet supported
FY2016/17	710		
FY2017/18	1,758		

Indicator 21: Couple-years of protection in sites supported by FC+			
Definition: The estimated protection provided by family planning services, based upon the volume of all contraceptives distributed to clients during the reporting period			
Additional description/context: USAID-endorsed conversion factors for each family planning method will be used to calculate CYP.[41] All CYP will be credited to the year in which the method was distributed, rather than annualizing CYP.			
Data source and collection: Collected semi-annually from facility FP registers by FC+ staff and in-country partners			
Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	28,430	40,039	
FY2014/15	90,500	107,985	
FY2015/16	**153,261**	**195,986**	
FY2016/17	145,496		
FY2017/18	180,000		

Indicator 22: Number of FP counseling sessions provided to clients
Definition: # of counseling sessions provided to clients at FC+ sites regarding FP methods.

[41] Office of Sustainable Development, Bureau for Africa, USAID. Health and Family Planning Indicators: A Tool for Results Frameworks Volume I. Accessed: January 20, 2014.

Additional description/context: As a woman may receive more than one FP counseling session in a given quarter, this indicator represents number of service encounters, rather than numbers of individual clients.

Data source and collection: Collected semi-annually from facility FP registers by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	53,698	38,373	
FY2014/15	117,800	149,610	
FY2015/16	**204,532**	**366,038**	
FY2016/17	186,232		
FY2017/18	80,000		

Indicator 23: Completion of partographs and management of labor according to protocol at sites receiving support for strengthening partograph use

Definition: A two part indicator will be used to assess partograph completeness and management of labor according to protocol.

Part 1: Mean partograph completion score for labor records reviewed during the reporting period. Partograph completion scores will be based on five key items that should be present in all records, whether labor was normal or prolonged. 1 point will be assigned for each item, for score range from 0 to 5. These are selected based on USAID/MCHIP/WHO tools and guidelines. They are:

- Existence of partograph in labor & delivery file.
- Fetal heart rate recorded every half hour on partograph.
- Contractions plotted every half hour on partograph.
- Maternal pulse recorded at least every half hour on partograph.
- Blood pressure recorded at least every four hours on partograph.

Part 2: % of partographs with action line reached in which the correction actions were taken.

Additional description/context: This information will be collected during medical monitoring supervision visits using FC+ medical monitoring tool. A systematic sample of up to 25 labor & delivery records for the reference period will be reviewed. Instructions for drawing a systematic sample are included in the monitoring tool.). Information from partographs will be abstracted using a standardized form. Data will only be collected from sites where FC is working to strengthen the correct use of the partograph.

Data source and collection: Collected annually from medical monitoring reports by FC+ staff and in-country partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	0	NA	

FY2014/15	50% of sites receiving a mean score of ≥4 on reviewed partographs; 60% of reviewed partographs responding appropriately action if action line reached	18% of sites receiving a mean score of ≥4 on reviewed partographs; 78% of reviewed partographs responding appropriately action if action line reached	
FY2015/16	**60% of sites receiving a mean score of ≥4 on reviewed partographs; 60% of reviewed partographs responding appropriately action if action line reached**	**24% of sites receiving a mean score of ≥4 on reviewed partographs; 75% of reviewed partographs responding appropriately action if action line reached**	
FY2016/17	65% of sites receiving a mean score of ≥4 on reviewed partographs; 65% of reviewed partographs responding appropriately action if action line reached		
FY2017/18	70% of sites receiving a mean score of ≥4 on reviewed partographs; 70% of reviewed partographs responding appropriately action if action line reached		

Objective 5: Strengthened evidence base for approaches to improve fistula care and scaled up application of standard monitoring and evaluation indicators for prevention and treatment

Indicator 24: Number of evaluation or research studies completed

Definition: # of evaluation or research studies completed that address fistula care services.

Additional description/context: Studies may include evaluation of models of prevention and repair service delivery, quality assessment and improvement research, evaluation of clinical approaches, and assessment of strategies to reduce barriers to fistula treatment. Annual report will list studies by study name, location, and status (i.e., in development/ ongoing/ complete). Completion will be defined as the submission of a final study report to USAID or the submission of a manuscript documenting study findings for publication.

Data source and collection: Collected annually from program research reports by FC+ staff and research partners

Benchmark Values

Year	**Target**	**Actual**	**Notes**
FY2013/14	0	0	
FY2014/15	**1**	**1**	Population Council formative research in Nigeria completed; Uganda pending.
FY2015/16	2	2	Uganda formative research completed, Nigeria communications assessment completed
FY2016/17			
FY2017/18	5		

Indicator 25: % of supported sites reviewing fistula monitoring data bi-annually to improve fistula services

Definition: Numerator: # of sites in which fistula monitoring data are reviewed at the facility to assess program progress / Denominator: # of supported sites X 100

Additional description/context: This indicates the proportion of supported FC+ sites with a functioning process for reviewing fistula monitoring data in order to improve services. A functioning review process is defined as a team of staff from the site who meet at least twice a year[42], with or without outside assistance (e.g., supervisory teams, FC+ staff) to review and discuss the data and make program decisions to improve fistula services based on these data.

Data source and collection: Collected semi-annually from program monitoring reports by FC+ staff and in-country partners

[42] The ideal is for these data to be reviewed on a monthly or quarterly basis, depending on service volume at a particular facility. However, experience from the original FC project indicates that this is very difficult, given shortages in human and other resources. FC+ will advocate with partner facilities to strengthen data monitoring and review systems, but has noted that in the approved PMP that bi-annual review is the minimum achievable floor for this indicator.

Benchmark Values			
Year	**Target**	**Actual**	**Notes**
FY2013/14	40%	NA	
FY2014/15	45%	55%	
FY2015/16	**50%**	**68%**	
FY2016/17	70%		
FY2017/18	75%		